MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY ARROLL b. COUNTY YOUNG MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR JOWN (If outside corporate limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b bon papers. Pag within 72 hours write RURAL end give nearest town) months SY RESVITTE 100/10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RESIDENCE ON A FARM? filled d. STREET ADDRESS Hospita Mbell YES NOX executed within completely NAME OF Middle DATE Month Day Year DECEASED event, MOS May car (Type or print) DEATH 1966 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. and cor 7. MARRIED NEVER MARRIED 9. last birthday) | Months | Hours any CA KR WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT pe during most of working life, even if retired) INDUSTRY COUNTRY? death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending it permit. Then 05 TOH MIR 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address 5 (Yes, no, or unkown) | (If yes give war or dates of service) Hespital cremation, 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. REUMONIOL day IMMEDIATE CAUSE (a) been sie the burial-tra gned DUE TO arterio-sclesosis Cenditions, If any, which gave rise to immediate as the prior to DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. for use Health PERFORMED? certificate the hospital or NO X YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Port I or Part II of Item 18.) detached f this 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED be de State factory, street, office bldg., etc.) Hour a.m. While Not While After Id be d at work at work p.m. retained should ith the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the and that death occurred at AM, from the causes and on the date stated above. saw the deceased alive on. SIGNATURE 22b. DATE SIGNED 22a. 4 may be page . ATTENDING PHYS. DIRECTOR PHYSICIAN'S TO HOSPITAL FUNERAL 22d. **ADDRESS** director, p NAME (Type) + nances rie 600 DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. 20 REMOVAL (Specify) Burial Woodlawn Woodlawn 24. FUNERAL DIRECTOR **ADDRESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE & Sons Co.4905 York Rd. H.W.Jenkins VR A15 (4) 20M 1/65

28430 THE REPORT OF THE PARTY OF THE ARYLAND STATE DEPARTMENT OF HEALTH

18830 CARROLL MARYLAND CARROLE RURAL WESTEINSTER 44 YEARS RURAL WESTAINSTEIL ROUTE#2 Z# BTUOR JOHN THOMAS BANKERT MAY 12 bl MALE WHITE NOV 2 1898 67 CARROLL MARYLAND USA MECHANIC DAIRY ANNA MISSOURE LANDER T GEORGE O. BANKERT WESTAINSTEN PIRELIAND ACUTE COROWARY THROADSU --ACTERIOSCIFICIE CORDIO CELEBRAL VAS, DISZYFAN MAY IZ bb MAY David Illo Week 5-12 66 DANIEL I WELLINEN INGIDCE RD WESTMINSTEINE St. Large Matery William, Dresh Do. 14.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06741 CERTIFICATE OF DEATH executed within 24 haurs after death funeral 1 and deat 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. County Carroll Baltimore City o. STATE Marvland MARYLAND hours after filled in by the fu papers. Pages b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town) c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Sykesville Baltimore A das e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS and in any event, within 72 NO Se 3925 Beech Avenue Springfield State Hospital YES and campletely fil remave carban p 3. NAME OF Middle 4. DATE Month Lost Doy Year DECEASED 1966 Mav GEORGIANA ELLIOTT BAUER DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7. MARRIED **NEVER MARRIED** Months irthdoy) Days Hours 3-10-86 WIDOWED DIVORCED White Female 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT U.S.A. during most of working life, even if retired) (INDUSTRY Ohio The law requires that the death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar remaval, ph Ida X Maiden Marie XXX Morrowx Elliott 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO. permit. Records, Springfield State Hospital Unknown No IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c).

PART I. DEATH WAS CAUSED BY: Mycardial infarction INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Bay Corenary Occlusion Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been irectar, page 3 shauld be detached far use as the hauld be filed with the State Dept. af Health priar ta Yrs. Arterioscelerotic Cardio-Vascular Disease PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)
CBS assoc. with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? NO YES 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) foctory, street, office bldg., etc.) Hour o.m. Not While 19 ot work 1900, that (I) (we) last 3-9-56 21. I certify that (I) (this hospital) attended the deceosed from_ M, fram causes and an the date stated abave. and that death accurred at 4:30 13/66 saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. director, page 3 shauld be filed v DIRECTOR PHYS. 22d. ADDRESS Springfield Sykesville, State Hospital Maryland 21784 22c. PHYSICIAN'S NAME (Type) Antonius Glahm 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (Stote) (County) REMOVAL (Specify) Greenmount Baltimore Cremation Md 0 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR 28 Sons Co. VR A15 (4) 20 M 1/66 York Rd. ns (Mclayles DATVAY

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06742 24 hours after death filled in by the funeral papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll buriof-tronsit permit. Then please remove corbon papers. Pages 1 burial, cremation, or removol, and in any event, within 72 hours after MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give negrest town) 2 mos. 22 dys Takoma Park e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NO G Springfield State Hospital 7h07 Carroll Avenue YES 4. DATE 3. NAME OF Middle Last Doy Year completely DECEASED ANDREW (NMN) BENNETT Sr. May 8 DEATH (Type or print) requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours Doys Male Whi te WIDOWED DIVORCED 7-22-83 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **Tailor** COUNTRY? INDUSTRY physicion Tailoring Hungary U.S.A. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Naturalized Joseph Benvo Unknown 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, or unknown) (If yes give wor or dotes of service) 215-34-3178A Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Heart & Kidney Failure IMMEDIATE CAUSE (o). Page 4 moy be retained by the hospital or ottending physician. DUE TO Conditions, if ony, which gove (b) Arteriosclerotic heart disease & nephrosclerosis vears rise to immediate cause (o), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate hos been be detached for use os the Stote Dept. of Health prior to PARL II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)

Chronic brain syndrome associated with alcohol intomication with 19. WAS AUTOPSY PERFORMED? YES T NO psychotic reaction. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While 19 at work 21. I certify that (1) (this haspital) attended the deceased fram_ 2-16-66 5-8-66 ... 19 ... that (1) (we) last director, page 3 should should be filed with the .0:55M. From causes and an the date stated above. , and that death accurred at 5-8-66 19 saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED ATTENDING G 5-8-66 M.D. DIRECTOR PHYS. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland 21 78h Octavio A. Ruiz. 230. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 28d. LOCATION (City or Town) (County) (Stote) AQVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Munices VR A15 (4) 20 M 1/66

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Burial Md. Manchester Immanuel 25a. REC'D BY RECISTRAR | 25b. RECISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR Md. Tipton-Eline Hampstead. 1966 VR A.15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 r death hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY y filled in by the fu papers. Pages 1 hin 72 hours after of b. COUNTY MARYLAND CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesvifte d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE event, within 72 ON A FARM? 1 stong 90 arte. NO X completely ive carbon p within 3. NAME DE Middle 4. DATE Month Day DECEASED DF 0527 na? (Type or print) 0 DEATH 19 executed remove 6. CDLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Months Days Hours 0110 WIDOWED [physician ; and in 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT certificate be during most of working life, even if retired) INDUSTRY COUNTRY? now eur 13. FATHER'S NAME MOTHER'S MAIDEN NAME removal attending printing pr OHK 11 1 orns 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address been signed by the atten the burial-transit permit. It to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN PHYSICIAN: The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: neumanion attending physician. 1)014 IMMEDIATE CAUSE (a) DUE TO noxal yeals Conditions, If any, which gave rise to Immediate **DUE TO** (a), stating as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY for use Health use PERFORMED? certificate CERTIFICAT gotenio-releteris. ND I YES X 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) this certifidetached for bept. of b DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) be de State I factory, street, office bldg., etc.) Hour a.m. While Not While After ATTENDING 19 at work at work the FUNERAL DIRECTOR: /
lirector, page 3 should hould be filed with the 21. I certify that (I) (this hospital) attended the deceased from 19 0 and that death occurred at 500 M, from the causes and on the date stated above. saw the deceased alive pn_ 19 22a. SIGNATURE 22b. pe ATTENDING STAFF PHYS. DIRECTOR M.D. PHYS. 4 may TO HOSPITAL PHYSICIAN'S director, p 22d. ADDRESS NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR GREMATORY 230 (State) 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 1966 VR A15 (4) 2DM 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death. funeral and PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY Carroll a. COUNTY by the fages 1 urs after Carroll MARYLAND Maryland CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b ve carbon papers. Pagevent, within 72 hours hours 15 years Westminster RD 3 Westminster RD #3 filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO X completely f executed within Year 3. NAME OF First Middle Last 4. OATE Month Day OECEASEO CHARLES BROWN BAYNE DEATH MAY 1966 (Type or print) AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIEO last birthday) | Months | Days any male white Oct. WIOOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 12. CITIZEN OF WHAT E 11. BIRTHPLACE (County & State, or foreign country) ician lease and ir COUNTRY? auto body & fender repair man Howard County, Maryland U.S.A physi ā removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ing ph Then Albert E. Brown Margaret Bayne 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 17. INFORMANT 16. SOCIAL SECURITY NO. Address ed by the attenctransit permit. (Yes, no, or unkown) | (If yes give war or dates of service) death same 213-01-9219 Mrs. Charles B. Brown INTERVAL BETWEEN 18. CAUSE OF OEATH [Enter only one cause pen line for (a), (b), and (c). al-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a signed burial, burial, DUE TO Conditions, if any, which (h) peen gave rise to immediate the r DUE TO cause (a), stating the prior underlying cause last. (c) certificate has as WAS AUTOPSY PERFORMED? CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CEATH BUT NOT RELATED TO THE TERMINAL CISEASE CONDITION GIVEN IN PART 1(a) 19. for use NO X YES [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING IT of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) After this MEDICAL (County) (State) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bidg., etc.) Hour a.m. Not While be retained by at work ATTENDING at work TO HOSPITAL OR A. Page 4 may be retained.
TO FUNERAL DIRECTOR: After the page 3 should retain the filed with the should ith the S 21. I certify that (I) (this hospital) attended the deceased from. 1966, and that death occurred at 4/0M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNEO 22a. SIGNATURE STAFF ATTENDING PHYS. DIRECTOR PHYS. ADDRESS PHYSICIAN'S NAME (Type) 22c. (State) BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. REMOVAL (Specify) Westminster. Westminster Cemetery Maryland burial Mav 16 1966 25a. REC'O BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL OIRECTOR ADDRESS 1966 VR A15 (4) 15M 4-64

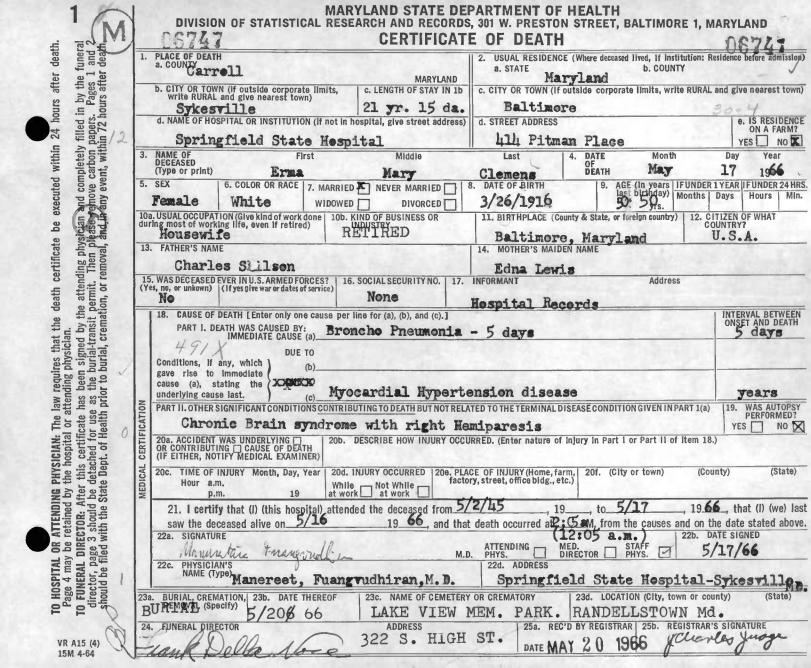
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission), a. CDUNTY b. COUNTY imore City CARROLL Pages 1 urs after Maryland MARYLAND b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b papers. Pag hin 72 hours 18yrs.3mo.22days Baltimore 2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? 1844 W. Saratoga Street within Springfield State Hospital ND X carbon NAME OF DATE Month **First** Middle Last Day DECEASED MAY DEATH (Type or print) (NMN) BRUNNER 19 66 BEULAH executed 6. COLOR OR RACE | 7. MARRIED TO NEVER MARRIED DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IIF UNDER 24 HRS emove last birthday) Months P 8-2-1891 WIDDWED [White physiolan a in please re val, and in a 1Da. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even If retired) INDUSTRY COUNTRY? Housewife

13. FATHER'S NAME Maryland U.S.A. death certificate 14. MOTHER'S MAIDEN NAME attending ph ermit. Then remova Addison Cephus Fox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Henrietta Bell ed by the attend transit permit. cremation, or r 16. SOCIAL SECURITY NO. 1 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) Springfield State Hospital, Sykesville, Md. No None INTERVAL BETWEEN 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).] -transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Atteriosclerotic Cardiovascular disease years ttending physician. been signed the burial-transport to burial, cre Bronchopneumonia days DUE TO Chronic Pulmonary Emphysema Conditions, If any, which vears (b) gave rise to immediate Old Granuloma, left lower lung DUE TO cause (a), stating the years underlying cause last. as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? CERTIFICATI CBS associated with cerebral arteriosclerosis, without qualifying YES X ND 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 2Da. ACCIDENT WAS UNDERLYING of DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) is a (State) 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (County) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. Not While at work at work 19 48 b the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should iled with the 1966, and that death occurred at 5: 5 % Prom the causes and on the date stated above. saw the deceased alive on_ 5- 27 22a. SIGNATURE MED. STAFF DIRECTOR PHYS. 12 5 - 27-66
Springfield State Hospital M.D. may TO FUNERAL director, pa should be fill paj HOSPITAL 22c. PHYSICIAN'S 22d. ADDRESS Sykesville, Maryland Samuel P. Wise M.D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, EMDVAL (Specify) FUNERAL DIRECTOR REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 25a. A15 (4)

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	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR	RYLAND
7 e	08748 CERTIFICATE OF DEATH	6742
s I and 2 frer death.	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE b. COUNTY MARYLAND MARYLAND	V
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) c. CITY OR TOWN (if outside corporate limits, write RURAL and Carlot of the corporate limits, write RURAL and Baltimore City, 21217 d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	Springfield State Hospital 803 Chauncey Avenue	YES ND
	OECEASED (Type or print) Will NMN COOK DEATH 5	Day Year 3 19 66
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) Months Day male Negro WIDOWED DIVORCED ?-?-1907 58-2 yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZ	
1	10a. USUAL OCCUPATION (Give kind of work done) during most of working life, even If retired) 10b. KINO OF BUSINESS OR UNIX OF	ITRY?
	Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
-	(Yes, no, or unknown) (If yes give war or dates of service) Unknown Hospital Records	
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOP NEWMONIA	NTERVAL BETWEEN ONSET AND DEATH
	Conditions, If any, which gave rise to Immediate (b) Carabral thrombosis	4 2195
	cause (a), stating the DUE TO HYPERTENSIVE CARDIOVASCUMA DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	2 YEARS 19. WAS AUTOPSY
5	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome of unknown or unspecified cause without qualifying phrase. 202. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	PERFORMED? YES NO
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work 19 at work	(State)
	21. I certify that (tx(this hospital) attended the deceased from 11-7-, 1963, to 5-3, 1966, saw the deceased alive on 1966, and that death occurred at 3.74M, from the causes and on the 22a. SIGNATURE 22b. DATE	
	22c. PHYSICIAN'S ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 5 22c. PHYSICIAN'S	-3-66
	NAME (Type) S.P. Wise III Springfield State Hospital	(04-44)
	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or count) REMOVAL (Specify) May 9 466 V. Fund, Wed School DA LTI FURCE, Med 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S S	ol,
X	Frank H. Newell Glesville 8- My DAMAY 11 1966 yellarles	Judge
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militaria il mangriotta di si sull'antico di mangrio di mencia il territori di si s is many passed to plantique el plantique participate the Panel again of the new growings are the second of the working and the The same of the sa The probability of the companion of the company chartler, media backing and to meaning to hardware slow about it AND THE PROPERTY OF THE PROPER

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. and 2 death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY hours after CARROL MARYLAND C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits. C. LENGTH OF STAY IN 1b filled in by papers. Page in 72 hours write RURAL and give nearest town) Sykesville Balt: more d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d STREET ADDRESS ON A FARM? Spring-lield State 3/08 WALDrook NO X YES etely bon p NAME DE DATE Middle Month Year DECEASED (Type or print) Coskery Butler DEATH - AURENCE MAY 1966 6. COLOR OR RACE | 7. MARRIED 5. SEX emove any eve DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. NEVER MARRIED last birthday) | Months | Davs 9-27-80 85 yrs. MAle WIDOWED X DIVORCED [attending physician a ermit. Then please re 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) death certificate be INDUSTRY COUNTRY? UNKNOWN MARYLAND ZI.S. A. Salesman 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Eliz Abeth 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT (Yes, no. or unkown) (If yes give war or dates of service) 219-05-6732 Patient's Record-Spring field State Hospital 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN signed by urial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) retained by the hospital or attending physician. Heart failure Davs been sight the burial-tra DUE TO Coronary arteriosclerosis Years Conditions, If any, which (b) gave rise to immediate as the prior to cause (a), stating the DUE TO underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? YES Y NO T 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 00 MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) DIRECTOR: After tage 3 should be de Hour a.m. While Not While at work at work to 5-18 21. I certify that (I) (this hospital) attended the deceased from 5-24-6 3 19 . 1966 that (I) (we) last 19.66, and that death occurred at 11 's. M. from the causes and on the date stated above. 5-18 saw the deceased alive on. 22a. SIGNATURE 22b. OR page MED. DIRECTOR Page 4 may PHYSICIAN'S O FUNERAL director, pa 22d. ADDRESS NAME (Type) BURIAL, CREMATION, 1 23b. 23d. LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY (State) FUNERAL DIRECTOR REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 20M 1/65 Muniles & 1966

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY a. STATE Maryland Carroll Baltimore City MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Baltimore 26yrs.5mos.28dvs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3 to Page State hours Springfield State Hospital 1519 Retreat St. NO DO YES 3. NAME OF Middle Last DATE Month Year DECEASED the Lucia XXXXXX LUCTLLE (Type or print) (DeBAUFRE DEATH MAY 19 With 6. COLOR OR RACE 5. SEX 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS lest birthday) | Months | Deys Hours Female White 2 WIDOWED Sep DIVORCED 2-17-03 63 Vrs. and 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Sewingfactory worker; saleslady Maryland U.S.A 13. FATHER'S NAME MOTHER'S MAIDEN NAME William Fitzpatrick Mary Colwell File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) permit. removal, No Unk. Records, Springfield State Hospital 18. CAUSE DF DEATH [Enter only one couse per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Asphyxia by occlusion of nose & mouth by patient 50 burial-transit Minutes lying on right side and nose cremation, (b) Acute edema and congestion of lungs Conditiona, If any, which Minutes risa to immediate DUE TO (a), stating tha 10 used as a to burial, underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY CERTIFICATION PERFORMED? Chronic brain syndrome associated with convulsive disorder, with YES M NO T psychotic reaction 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 0 should l 3 shou agent, MEDICAL 20c. TIME OF INJURY Month, Day, Year I 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection Inquiry should FUNERAL DIRECTOR: death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER for your DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 0 director. retained f NAME (Type) W. Glenn Speicher. Addless (State Note Now lot LOCATION (City, town or county) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Balto. Nat 0 timone, Md. ISTRAR'S SIGNATURE Burial emetern 24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balta. St. VR A15ME (5) 1/65

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	1 (M)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
غ.	E 24	06751 CERTIFICATE OF DEATH
er death.	e funeral 1 and 2 er death,	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OF TOWN (if outside corporate limits and allowed accounts town) County Carroll County County Carroll County Carroll County Carroll County Carroll County Carroll County County Carroll County County County Carroll County County County Carroll County County Carroll County Cou
hours after	tely filled in by the foon papers. Pages 1 within 72 hours after	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town)
- STILLS	in b	Westminster 50 years Westminster 6. /
9 4	filled papers in 72 h	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
	thing thing	83 Washington Road YES NO X
with	npletely carbon nt, with	3. NAME OF First Middle Last 4. DATE Month Day Year OF DECEASED (Type or print) EDNA MAY DITMAN DEATH May 22. 1966
Pa	comple ve cart event,	5. SEX 6. COLOR OR RACE 7. MARDIED MARDIED 8. DATE OF BIRTH 9. AGE (In years I F UNDER 1 YEAR) FUNDER 24 HRS
executed within	and co emove any ev	female white WIDOWED X DIVORCED March 5, 1880 86 yrs. Months Days Hours Min.
	02.00	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
4		housewife Marston, Carroll Co., Md. U.S.A.
1	oval, pa	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
T	ding p Then remov	William Franklin Mary E. Nusbaum
4	e attending bermit. Thi	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address
9	the a t per	Mrs. Helen D. Harbaugh, same 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),]
The law remises that the death certificate	d by the at ransit pern cremation,	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hermorluse ONSET AND DEATH LIMITED AND DEATH L
4	attending physician has been signed by t se as the burial-transit h prior to burial, crema	1 4221
90	physici n signe burial-t burfal,	Conditions, If any, which) DUE TO (b) Cardio - Vascular disease 3 years
	ding p been the bu	gave rise to immediate cause (a), stating the DUE TO
W 75	ttendii has be as th prior	underlying cause last. (c) arterio - selvosa (o genu
0	r att	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. (WAS AUTOPSY PERFORMED?
		YES NO
P. A. A.	hospital or atten s certificate has ched for use as pt. of Health price	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
No.	the hospi this ceri detached e Dept. of	
ATTENDING DUVELCIAN.	After this code be detached State Dept.	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. While at work at w
Į.	retained by CTOR: Aften Should be vith the Staf	21. I certify that (I) (this hospital) attended the deceased from may 22, 1956, to may 22, 1944, that (I) (we) las
	cro cro sho sho ith	saw the deceased alive on 22 1966, and that death occurred at 30/M, from the causes and on the date stated above
2	DIRE Se 3 Se 3 ed w	M.D. ATTENDING MED. STAFF DIRECTOR PHYS. D 5-23-46
TAI	may be tal DIR , page of filed	22c. PHYSICIAN'S 22d. ADDRESS
HACPITAL	e 4 ctor	NAME (Type) . L. 13,111ings/ea Westminster, Ind.
Ħ	Page 4 may be retained TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the	23a. BURIAL, CREMATION, 23b. DATE THEREOF / 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
-	R.	burial 5/24/66 Meadow Branch Cemetery nr Westminster, Maryland 24. FUNERAL DIRECTOR ADDRESS AFEC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	VR A15 (4)	Q. E. myers & Westminster mod MAY 25 1966 Icharles Judge
	15M 4-64	DATE: NO 1000 June 1000 Ju

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06746

TIFICATE OF DEATH	T	FI	CAT	E	OF	D	E/	AT	H
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	1	00000					00020	
	1.	PLACE DF DEATH a. COUNTY CARROLL MAI	RYLAND		E (Where deceased yland	L COMMITTEE	Residence before admission altimore	p)
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If	outside corporate	Ilmits, write RURA	L and give wearest town	1)
Я		Sykesville lyr.7mo.	.11da	Baltin	nore		30.4	
ı		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street	t address)	d. STREET ADDRESS			e. IS RESIDENC ON A FARM?	
2		Springfield State Hospital Sykesville, Maryland			ner Ave		YES NO	-
	3.	NAME OF First Middle DECEASED (Type or print) Emma Felica Evans	Dudl	e y	4. DATE DF DEATH	May	24. Year 19 66	
Ī	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARR	IED 8	B. DATE OF BIRTH	9. ACE	(In years IFUNDE birthday) Months	R 1 YEAR IF UNDER 24 HR	
J	F	emale Negro WIDOWED DIVORG	CED	12-19-92	73	yrs.	Days Hours Mill	
Į	1Da	. USUAL OCCUPATION (Cive kind of work done 10b, KIND OF BUSINESS	OR	11. BIRTHPLACE (Co	ounty & State, or for	reign country) 12.	CITIZEN OF WHAT COUNTRY?	
		ing most of working life, even if retired) INDUSTRY		Maryla	nd		U.S.A.	
	13.	FATHER'S NAME		14. MOTHER'S MAID	EN NAME			
	dis	George Evans		Emmali	ne Hammo	nd		
		. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY	NO. 17.	INFORMANT Reco	rds	Address	rest rest	
	(10	No None	S	pringfield	State H	ospital		
	Ī	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and					INTERVAL BETWEEN	ı
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscler	otic	Heart Disea	ase		ONSET AND DEATH	
		4201 DUE TO	19.00					
		Conditions, If any, which \ (b) Severe Coro	nary	Arterioscl	erosis		Years	
		gave rise to Immediate (cause (a), stating the DUE TO		100				
		underlying cause last.	monia				1 day	
	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU Chronic brain syndrome associat	TNOTRELA	TED TO THE TERMINAL D	ISEASE CONDITIO	NCIVEN IN PART 1(a	19. WAS AUTOPSY PERFORMED?	1
	ICAI	Chronic brain syndrome associat with psychotic reaction.	ed W1	th cerebra	T ar cert	OPCTAT OPT	YES X NO]
	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW IN. OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	JURY OCCU	RRED. (Enter nature of	Injury in Part i	or Part II of Item 1	8.)	
		2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED	120e PLA	CE OF INJURY (Home, fa	rm, 20f. (City	or town) (C)	ounty) (State)	-
	MEDICAL	Hour a.m. p.m. 19 While at work at work	factor	ry, street, office bidg., e	tc.)	0, (0,	control,	
	_	21. I certify that (i) (this hospital) attended the deceased	from	Oct. 13 .19	64tom	May24 . 196	6, that (i) (we) la	st
					: 20M, from th		the date stated above	
		22a. SICNATURE				22b.	DATE SICNED	
		the I k amoun	M.D	. PHYS.	DIRECTOR P		y 24, 1966	
		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS S	pringfie	ld State	Hospital	
		NAME (lype) Ilse Kamm, M.D.		_ S		e, Maryla		=
	23a	A DESCRIPTION OF THE PROPERTY		OR CREMATORY	23d. LOCATI	ON (City, town or c	ounty) (State)	
	24	FUNERAL DIRECTOR ADDRESS			C'D BY REGISTRA	25b. REGISTRA	R'S SICNATURE	
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Rone Stringfield State Consider, Attentional Control Control Control Control Severe Coronary arteribrolerants Attentional Control Control Control	4 4 4	5HhLynett	m ~ ~ ~ ~	едон
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THE MAY 2 OF 1996 ASSESSED ASSESSED.

X 1 (AA	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY
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is necessary, o the funeral e 5 may be Department after death.	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give hearest town)
ma mart	Hampslead Hanson 15 3
elay is necessary, d 3 to the funeral Page 5 may be State Department ours after death.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A heeler thereof I have 138 Broadway YES NO P
State hours	
ny d 2, an 2, an 3. M3.	(Type or print) Howard Hilliam Flickinger DEATH May 23 1966
ith. If all form P form P within	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
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er deat ive Pag with 1 and 2	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 11c. CITIZEN OF WHAT COUNTRY
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24 ho n Item Office File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes/no, or unknown) (If yes give war or dates of service)
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AL EXAMINER: This certificate should be executed within 24 hours after death. If any del the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and should be forwarded to the Chief Medical Examiner's Office along with form PM3. Tilles. 5.10R: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Si designated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent.	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: ONSET AND DEATH WAS CAUSED BY:
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EXAN cer nould les. R: P signa	death resulted from: Natural causes A Accident , Suicide , Homicide , Undetermined manner
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TY MEDICA execute the control of the	ACTUAL SIGNATURE OF CLOSE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 7
	EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER X Address Street CM Summer Control Summer Control
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/	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	06756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06743
HEALTH DEPT	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
	a. STATE b. COUNTY
ary, eral be be ath,	b. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town) write RURAL and give nearest town)
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AL EXAMINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form tiles. Tiles. Tiles. Tiles. Tiles.	(Yes, no, or unkown) (If yes give war or dates of service) 216-07-3846 mas Francis C- Febert Cheener
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cate for age	20c. TIME OF INJURY Month, Day, Year Hour a.m. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (State) 20f. (City or town) (State) 20f. (City or town) 20f
AL EXAMINEE the certific the certific the remainee the should be trifics. Tiles. GOOR: Page designated	21. I certify that I took charge of the remains described above, held an Autopsy [], Inspection X, Inquiry [], and In my opinion
L EXA ne ce shoul files. TOR:	death resulted from: Natural causes , condent Suicide , Homicide , Undetermined manner
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ry Medic execute execute Page of for you RAL DIRE	SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY
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D DEPUTY MEDICAL EXA please execute the c director. Page 4 shou retained for your files 0 FUNERAL DIRECTOR: of Health or its design	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
To direct ret	Burnal 6/3/66 Leisters Cernetry Westminster RD#4
02	24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR'S SIGNATURE 774.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital ar attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed Page 4 moy be retained by the haspital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to 3 should be 0 VR A15 (4) 20 M 1/66

within 24 hours after deoth.

REMOVAL (Specify) Holy Redeemer Cemetery 5/12/66. Ruck Inc. Balto. Md. 21214

23b. DATE THEREOF

Frances Reid Nabors. M. D.

22c. PHYSICIAN'S

23o. BURIAL, CREMATION,

NAME (Type)

2So. REC'D BY REGISTRAR 1966

PHYS. Springfield State Hospital

Sykesville, Maryland

23d. LOCATION (City or Town)

DIRECTOR

ATTENDING

22d. ADDRESS

PHYS.

M.D.

23c. NAME OF CEMETERY OR CREMATORY

Baltimore, Md. 2Sb. REGISTRAR'S SIGNATURE Klarley

(County)

e. IS RESIDENCE ON A FARM?

Dov

YES NO

Year

19 66

IF LINDER 24 HRS.

USA

Hours

INTERVAL BETWEEN

ONSET AND DEATH

months

19. WAS AUTOPSY PERFORMED? YES

NO

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral hours afte 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) e. COUNTY b. COUNTY MARYLAND 1111 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give neerest town) NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress e. IS RESIDENCE ON A FARM? 28N YES INO NAME O DATE Month Day DECEASED OF (Type or print) DEATH 1966 AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE NEVER MARRIED last birthday) Months Deys WIDOWED DIVORCED certificate 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRE 12. CITIZEN OF WHAT COUNTRY? County & State, or foreign country done during most of working tife, even if retired) busilsuber 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address that the (Yes, no, or unknwn) | (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line toy (a), (b), and (c).] INTERVAL BÉTWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6): 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert t or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH MEDICAL (County) (State) 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) 20c. TIME OF INJURY Month, Dev. Yeer fectory, street, office bldg., etc.) While Not While Hour e.m. at work __at work p.m. 03 21. I certify that (1) (this hospital) attended the deceased from Devil 196.6., and that death occured at S.A.M., from the causes and on the date stated above saw the deceased alive on... 22b. DATE 22e. SIGNATURE ATTENDING STAFF SIGNED PHYS. O HOSPITAL
death. Page 4 PHYS. DIRECTOR M.D. 22d. ADDRESS PHY SICIAN S NAME (Type 23d. LOCATION (City, town or county) BURIAL, CREMATION, 236. DATE THEREOF (State) 0 5 8 REMOVAL (Specify) Md. 5-10-66 St. Bartholomew's Manchester 25a, REC'D BY REGISTRAR ADDRESS 25b. REGISTRAR'S SEGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 1966 15M 7/61 Tipton-Eline Hampstead , Md.

MARYLAND STATE DEPARTMENT OF HEALTH

8 ELECTRICAL STATE OF THE SERVICE STATE OF THE SERVIC

3 1 (M	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	05758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY c. STATE b. COUNTY
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ssar unera ay b tmen tmen	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
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algurs algue	13. FATHER'S NAME 141 MOTHER'S MAIDEN NAME
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within 2 pencil in miner's 0 permit. I removal,	(Yes, no, or unkown) (If yes give war or dates of service) 219-44-6649 mm Charlotte H. Daylott, allen
with pend mine pern remo	18. CAUSE OF DEATH [Enter only one cause per line for (6), (b), and (c).] PART I. DEATH WAS CAUSED BY: ONSET AND DEATH ONSET AND DEATH
Exa Exa Insit	9711 IMMEDIATE CAUSE (8)
uld be executed "pending" in sf Medical Exan a burial-transit i cremation, or i	Conditions, If any, which (b)
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AINE rtific l be age ted	21. I certify that took charge of the remains described above, held an Autopsy , inspection Inquiry , and in my opinion
L EXAM ne cel should files. f0R: P	death resulted from: Natural causes Accident , Suicide X, Homlcide , Undetermined manner
CAL the the 4 slour from	CHIEF MEDICAL EXAMINER
MEDICA xecute t Page 4 for your	ACTUAL SIGNATURE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER TO 24 66
TO DEPUTY MEDICAL EXAMINE please execute the certific director. Page 4 should be retained for your files. TO FUNERAL DIRECTOR: Page of Health or its designated	NAME (Type) / W. GLENN SPEICHER Lides Strollolly, 480, Li Claro Muentler hard
O DEPUTY please edirector. retained O FUNERA	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAMS OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
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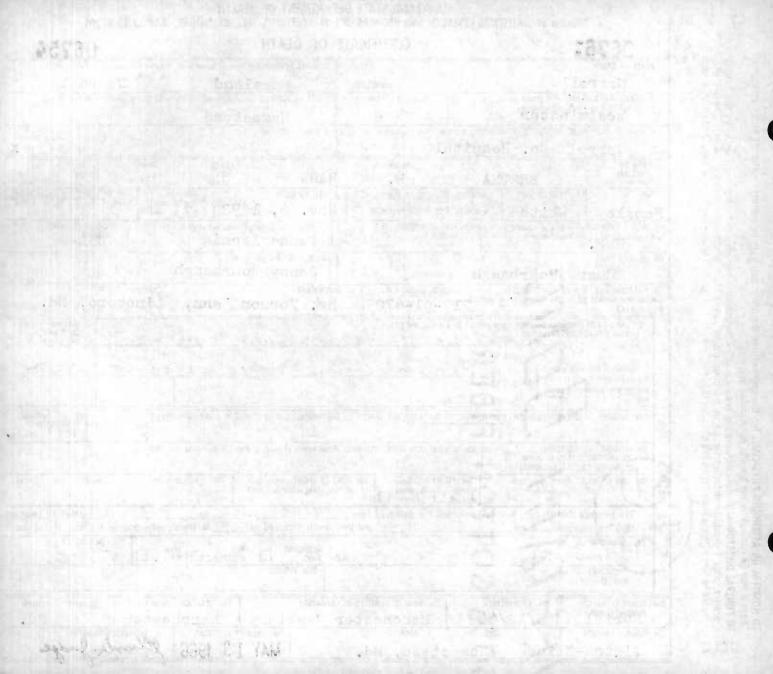
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	ithin 2	3.	Springfie	ald State H	ospita	Middle	3338 W.	Belvedere	Ave.	Da		ND L
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	and and remo	10	Female	white	WIDOWED		2-19-98	68	yrs.			197111
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	law reattendii has be e as the prior	NO	underlying cause PART II. DTHERS		(c) ONS CONTRIB	UTING TO DEATH BUT NOT RE	LATED TO THE TERMINA	L DISEASE CONDIT	ION GIVEN IN P	ART 1(a) 19	. WAS AU	TOPSY
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	certicolar pospit	CERTIFICATION	20a. ACCIDENT OR CONTRIBUT (IF EITHER, NO	WAS UNDERLYING ☐ ING ☐ CAUSE OF DEA TIFY MEDICAL EXAMI	(TH (NER)	DESCRIBE HOW INJURY OCC	CURRED. (Enter nature	of injury in Part	or Part II of	Item 18.)		
	OR ATTENDING PHYSICI by be retained by the host DIRECTOR: After this ce age 3 should be detache led with the State Dept.	MEDICAL		INJURY Month, Day,	Year 20d.	fan	ACE OF INJURY (Home, tory, street, office bldg.	farm, 20f. (Cit	y or town)	(County)	(S	tate)
	ING by the left be constant State	MED	p.:		While at_wor							
	OR ATTENDING I be retained by . DIRECTOR: After ge 3 should be . led with the State				pital) attend	ded the deceased from		19_66 to_5		, 19_66_, i		
	ATT reta reta 3 sh with	10	22a. SIGNATU	ceased alive Dn	01 8		at death occurred a			22b. DATE S	IGNED	auuv
	AL OR			er s.	glath	M	.D. PHYS.	MED. DIRECTOR	STAFF PHYS.	5 - 2	0-6	06
	TO HOSPITAL Page 4 may TO FUNERAL director, pag should be file		22c. PHYSICIA NAME (T	AN'S RITA	S.	GLAHN	22d. ADDRESS	NGF.	STATI	E HO	SP.	
	Page Fo FU direc	23	BURNAL, CREM		THEREOF	23c. NAME OF CEMETE	RY OR CREMATORY	723d. LOCA	TION (City, tow	or county)	(St.	ate)
	0	2	FUNERAL DIR	ECTOR / Wy	14,176	ADDRESS	Cell Come	REC'D BY REGISTR	AR 25b. RE	GISTRAL'S SIG	NATURE	
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MARYLAND STATE DEPARTMENT OF HEALTH

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	Divisi	on of STATIS			1 W. PRESTON STR	EET, BALTIMORE, MARYL	AND 21201	
	08761			CERTIFICATE	OF DEATH		0675	4
1. PLACE a. COL	OF DEATH			MARYLAND	o. STATE Mary	(Where deceosed lived, if institution b. COUN	Carroll	
b. CITY wri	OR TOWN (If autsi te RURAL and give i Westmir	de carparate limit nearest tawn) 15 ter)	s,	c. LENGTH OF STAY IN 16 2 Wks.		outside carparate limits, write RUR	AL and give nearest tawn))
d. NAA	ME OF HOSPITAL OR				d. STREET ADDRESS		e. IS RE ON A	ESIDENCE A FARM?
3. NAME	Carroll			A.L. Middle		La pare	YES	
DECEA (Type	SED or print)	BERT		М.	HANN	4. DATE Month OF S	9 1	Year 19 66
s. sex Fema		olor or race Vhite	7. MARRIED WIDOWED			.892 9. AGE (In years last hirthdoy) 73 yrs.	Months Doys Hour	
10o. USUA during ma	LOCCUPATION (Give st of working life, eve HWF	kind of work dane en if retired)		ND OF BÜSINESS OR DUSTRY	Pennsyl	y & State, ar fareign country) .vania	12. CITIZEN OF WHAT	
	Edward		ugh		Jenny F	NAME Rohrbaugh		
(Yes, no, o	DECEASED EVER IN U.S or unknown) (If yes	S ARMED FORCES?	16. 5		Mr. Verno	on Hann, Lin	eboro, Md	•
Cond rise t	CAUSE OF DEATH (I PART I. DEATH WAS titions, if ony, which a immediate caus ing the underlying	CAUSED BY: IMMEDIATE CAUSE DUE gave e (a),	(0) <u>L</u> 10 (b) <u>A</u> R	1/	TRICULAR	FAILURE PRT DISEM	INTERVAL E	D DEATH
PART	II. OTHER SIGNIFICA	ANT CONDITIONS	CONTRIBUTING TO	O DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	ONDITION GIVEN IN PART 1(a)	19. WAS AI PERFOI YES	UTOPSY RMED? NO
OR C	ACCIDENT WAS UNDER ONTRIBUTING (**) CAU THER, NOTIFY MEDICA	ISE OF DEATH	20b. DES	SCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in	Part I ar Part II af item 18.)		
	TIME OF INJURY MA		20d. IN While of work	Not While fact	CE OF INJURY (Hame, far tory, street, affice bldg., etc	rm, 20f. (City ar tawn)	(Caunty)	(State)
1 9	21. I certify the saw the decease SIGNATURE	at <u>(I)</u> (this ha ed alive on	spitol) attend	led the deceased fram_ 19_1966, and tha	t death occurred a	19 <u>66</u> ta 5/9 t <u>//</u> M, from causes (, 19 <u>66</u> , that (I) and an the date state 22b. DATE/SIGNED	(we) lo
	PHYSICIAN'S NAME (Type)	AS	fro	E SM	D. ATTENDING PHYS. 22d. ADDRESS	MED. DIRECTOR PHYS.	5/10/66	
23a. BUR REM	IAL, CREMATION, OVAL (Specify)	23b. DATE TH		23c. NAME OF CEMETERY OR Manches ter			er	(Stote) Md.
V -	ERAL DIRECTOR			ADDRESS		D BY REGISTRAR 2Sb. RE	ISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06762 requires that the death certificate be executed within 24 haurs after death death filled in by the funeral papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY Carroll Maryland Allegany MARYLAND within 72 haurs after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, Rural--Sykesville Cumberland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street padress) Polk Street Springfield State Hospital YES NO NAME OF Middle 4. DATE Lost Month Doy Year apletely DECEASED OF Margaret Hausman 66 (Type or print) DEATH M UNDER 1 YEAR S. SEX 6. COLOR OR RACE AGE (In years IF UNDER 24 HRS. 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Manths Doys Hours 7/19/96 white WIDOWED DIVORCED female 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? USA physician burial, crematian, ar remaval, and Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Catherine Schilling John Hausman IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, na. or unknown) I(If yes give war or dotes of service) Springfield Hospital records, Sykesville unknown no 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Cardiac failure IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove Bronchopneumonia days rise to immediate cause (a). DUE TO stating the underlying couse Page 4 may be retained by the haspital ar attending as the prior to b has been lost. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use 3 shauld be detached far use with the State Dept. af Health Manic depressive reaction, manic type. NO After this certificate I be detached far us 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o.m. foctory, street, office bldg., etc.) Not While 21. I certify that (\$\mathbb{X}\$ (this haspital) attended the deceased from 6/9/, 19 22 to May 13, 1966, that (\$\mathbb{X}\$ (we) last saw the deceased olive an May 13, 1966, ond that death occurred at 30 MM, from causes ond on the date stated above. FUNERAL DIRECTOR: 22b. DATE SIGNED 220 SIGNATURE ATTENDING M.D. DIRECTOR director, page should be filed Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS Buyukunsal, Naci M.D. NAME (Type) Sykesville, Maryland 23C NAME OF COMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) BURIAL, CREMATION 23b. DATE THEREOF (County) 0 REGISTRAR'S SIGNALURE 25g. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06763 CV requires that the death certificate be executed within 24 hours after death deoth filled in by the funeral papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland b. COUNTY o. COUNTY Carroll MARYLAND Montgomery event, within 72 hours after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 2mos.lldvs. Svkasville Silver Spring e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 10107 McKerney Ave. YES NO DE 3. NAME OF Middle 4. DATE First Last Doy Year and completely f remove carbon DECEASED (NMN) 19 66 ALETHE **HERRMANN** MAY DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 69 (In years AGE (In years S. SEX DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** Months Dovs Hours White 3-8-1897 and in any Female WIDOWED DIVORCED a, USUAL OCCUPATION (Give kind of work dane 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR COUNTRY? ottending physician opermit. Then please ring most of working life, even if retired) INDUSTRY Virginia

14. MOTHER'S MAIDEN NAME U.S.A. Nurse 13. FATHER'S NAME cremotion, ar removol, Joseph Larch Eleanor McKutchen 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war ar dates af service) permit. Unk. Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p ONSET AND DEATH Cerebral arteriosclerosis IMMEDIATE CAUSE (a) DUE TO Generalized Arteriosclerosis Years Conditions, if ony, which gave rise to immediate couse (a), DUF TO TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Poge 4 may be retained by the haspital or attending os the stating the underlying couse O FUNERAL DIRECTOR: After this certificate hos been Terminal bronchopneumonia Days WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) for use CERTIFICATION with the Stote Dept. of Heolth NO C 0 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS LINDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While at work at work pe 21. I certify that (I) (this haspital) attended the deceased fram2-17-66 , 19___, that (1) (we) last ___, and that death accurred at 0:15 M, tram causes and an the date stated above. 3 should saw the deceased alive an 5-1-66 22b. DATE SIGNED 220. SIGNATURE MED. DIRECTOR **ATTENDING** 5-2-66 X PHYS director, page 3 should be filed v M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN Agustin del Campo . M. D. NAME Type Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d-LOCATION (City or Tawn) (County) (State) 23a. BURIAL CREMATION. 23b. DATE, THEREOF REMOVAL (Specify) Geo. Co LINCOIN 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 DAMAY Melianelas 1966

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P	F 2ª F	1 1	06764 CERTIFICATE OF DEATH	757
	hours after death. d in by the funeral rs. Pages 1 and 2 thours after death.	7	PLACE DF DEATH a. CDUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Re a. STATE b. CDUNTY MARYLAND MARYLAND	sidence before admission)
	nours aft in by th s. Pages hours aft		b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH DF STAY IN 1b C. CITY DR TDWN (If outside corporate limits, write RURAL of Rural) Manchester (Rural)	2)06-1
	fille pape in 72	6	d. NAME OF HDSPITAL DR INSTITUTION (If not in hospital, give street address) RFP	e. IS RESIDENCE DN A FARM? YES ND
	executed within 24 h	3	(Type or print) Charles F Hersh DEATH May 2	Day Year 5 1966
	amy amy		Male W hate widdwed Divdrced July 19, 1019 86 yrs.	Days Hours Min.
	ficate be g physician en please oval, and in		farmer INDUSTRY Maryland	TIZEN DE WHAT
	certifical nding phy Then p	1	3. FATHER'S NAME 14. MDTHER'S MAIDEN NAME	
	ath certifica attending ph armit. Then n, or remova	1	John Hersh 5. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY ND. 17. INFORMANT Address	
	deat le at perm ion,		no 220-01-0428 Mrs. Minnie Hersh, Mancheste	
	hat the death c cian. ed by the atten transit permit. , cremation, or r		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arternoscleratic Carclio Vascular	INTERVAL BETWEEN DNSET AND DEATH
	requires that ding physician been signed the burial-train or to burial, cr		Conditions, if eny, which (b)	7 7
	aw requi ttending has been as the k prior to l		cause (a), stating the underlying cause last.	
	4. The law requires that the death certificate be tall or attending physician. ificate has been signed by the attending physicial for use as the burial-transit permit. Then please Health prior to burial, cremation, or removal, and it	CERTIFICATION	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTDPSY PERFORMED? YES ND
		CERTIF	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY DCCURRED. (Enter neture of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		MEDICAL	20c. TIME DF INJURY Month, Day, Year Odd. INJURY DCCURRED Country Hour a.m. Hour a.m.	nty) (State)
	0 0 0			that (11) (we) last ne date stated above.
	OR be DIRE			ATE SIGNED
	O HOSPITAL Page 4 may O FUNERAL I director, pag	/	22c. PHYSICIAN'S NAME (Type) W. H. FOARD M.D 22d. ADDRESS MAKE (Type) W. H. FOARD M.D MANCHES + C. M.D	1.
	TO HO Page	2	Burial, Cremation, 23b. Date thereof 23c. Name of Cemetery or Crematory 23d. LDCATION (City, town or countried Manchester Cemetery Manchester	Md.
	VR A15 (4)	(10)	Tipton-Eline Hampstead, Md. 25a. REG'D BY REGISTRAR 25b. REGISTRAR' 25b. R	n .
	TOIN 4-04			

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay cessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be TO DEPUTY MEDI

VR.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. director. Page 4 shour retained for your files. AI 5ME (5) 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
OCT Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	O N	IEDICAL EXAMIN	EK 3 CEKII	FIGATE OF	F DEATH	116	1656
1. PLACE OF DE.	ATH		2. USUA	L RESIDENCE (Whe	re deceased lived, If ins		ice before admissio
Carro	בו	M/	ARYLAND a. ST.	Maryland		Baltin	nore Cit
b. CITY OR TO write RUR	OWN (if outside corpora AL and give nearest to	wn)	HAT IN 10 C. CITT C	R TOWN (If outside	o corporate limits, wr	Ite RURAL and	give nearest tow
Sykesy	llle	2yrs.lmo		Baltimore		3	0 - 4
d. NAME OF I	OSPITAL OR INSTITUTI	ON (if not in hospital, give stree	et address) d. STREE	T ADDRESS			e. IS RESIDENCE ON A FARM?
Spring	field State	Hospital	92	29 Frankli	intown Road		YES NO S
NAME OF DECEASED		Irst Middle	Las	4. D	ATE Month	n Da	ay Year
(Type or prin	7011	NIEL HENRY	HOWAI	RD D	EATH MAY	5	19 66
5. SEX	6. COLOR OR RACE	7. MARRIED NEVER MARI			1 1 1 6 1 4 1 1 1 1	Months Days	Hours Mic
Male	Negro	WIDOWED TO DIVOR			76 yrs.		
luring most of wo	ATION (Give kind of wor) rking life, even if retir	k done 10b. KIND OF BUSINESS ed) INDUSTRY	OR 11. BIR	THPLACE (State or	foreign country)	12. CITIZE	N OF WHAT RY?
Labo				Maryland		U	S.A.
13. FATHER'S N	and the second second			HER'S MAIDEN NAM			
	Henry Howard				Inn Gaither		
(Yes, no, or unkown	(If yes give war or dates	of service)	_				
No	1	216-12-490		s, Springi	field State	-	
	DEATH [Enter only or DEATH WAS CAUSED B'	ne ceuse per line for (a), (b), an				10	TERVAL BETWEEN
1/	IMMEDIATE CAUSE	Y: Acute myocar	dial infarci	tion		M:	inutes
Conditions	DUE	10				77	
	to Immediate	(b) Coronary art	arroscretos.	.8		10	ears
cause (a), underlying co	starting rite (E TO				160	
		ONSCONTRIBUTING TO DEATH BE TO SC.	UT NOT RELATED TO THE	TERMINAL DISEASE	CONDITION GIVEN IN	PART 1(e) 19	. WAS AUTOPS
ELCBS ass	oc. with ce	rebral arteriosc.	lerosis, wit	thout qual	ifying phr	290	PERFORMED?
5					0 0 1	ace	YES NO T
20a. EXTER	NAL CAUSE WAS	20b. DESCRIBE HOW II	VJURY OCCURRED. (Ente	or nature of injury			
20a. EXTERIPRIMARY CAUSE OF DE	NAL CAUSE WAS or CONTRIBUTING TATH.	20b. DESCRIBE HOW II	VURY OCCURRED. (Ente	er nuture of Injury			
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			Address ngfield State Ho	ospital
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		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIF	MORE 1, MARYLAND
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omp omp in 7		(Type or print) JAMES CLAUDE LANKSON DEATH MA	Y 9 1966
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he a he a nova	1	No 219-07-8112 700 17 17 17 17 17 17 17 17 17 17 17 17 17	ZTRAINSTER MI
es the		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY:	ONSET AND DEATH
hysich hy		IMMEDIATE CAUSE (a) CARCINOMA OF RECI	JM. GMONIA
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e la andir cren		Conditions, if eny, which (b)	
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HY e be or u	CERTIFICATION	OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of itam 18.)	
ealth ealth	1		(County) (State)
Affect of H	MEDICAL	Hour a.m. While Not While fectory, street, office bldg., etc.)	(County) (Sidile)
Se de	12	21. I certify that (I) (this hospital) attended the deceased from M. H. 19 to M.A.	19 (1) (we) last
Pi o		saw the deceased alive on A. A	
Stal		220 SIGNATURE ATTENDING 1 MED STAFF _	22b. DATE SIGNED
14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		M.D. PHYS. DIRECTOR PHYS.	5/9/66
Page VERA		122c. MAYSICIAN'S 19 BIDGE RD WELLIVER 19 BIDGE RD WE	STMINSTER MD
HOSPI ath. Pa FUNE ector, p	23	3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City,	town or county) (State)
5 5 5 g g		Burial 5/12/66 Grace Methodist Cemetery Baltimore	
VR A15 (4)	24	4 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 256.	registrar's signature
15M 7-62		J. F. Eline & Sons Reisterstown, Md. DATE MAY 10 1966	The same of the sa

Sinis? Sine e cons deiscerstown, bu. MAY 10 2856 / May MY TO BE A THE DE TAM

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06768 CERTIFICATE OF DEATH 06761 the funeral ages 1 and 2 rs after death 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Carroll Maryland b. COUNTY d completely filled in by the fur move carbon popers. Pages 1 ny event, within 72 hours after MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neorest town) 21 days Baltimore Rural--Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled 6512 Glenoak Avenue Springfield State Hospital YES NO X any event, within requires that the death certificate be executed within NAME OF Middle Lost DATE **Eirst** Doy Year DECEASED 10 19 66 NMN Kayer May (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 8. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 8 ast birthdoy) Months Doys Hours 5/5/81 white WIDOWED DIVORCED female 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? the attending physician sit permit. Then please Maryland USA housewife 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removol, unknown Henry Mackert 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 220-46-90#3 Springfield Hospital records, Sykesville 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH Congestive heart failure IMMEDIATE CAUSE (o) DUE TO Mitral insufficiency years Conditions, if ony, which gove rise to immediate couse (o), **DUE TO** stoting the underlying couse Poge 4 moy be retoined by the hospitol or offending O FUNERAL DIRECTOR: After this certificate hos been d for use os the of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Chronic brain syndrome associated with senile brain disease with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES NO 20o. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While ot work . 1966, that (44 (we) lost 21. I certify that (this haspital) attended the deceosed from. e deceosed from 4/19/, 1266 to 5/10/, 1966, that (4) (we) lost 1966, and that death occurred above. 1966 3 should saw the deceased olive an 5/10/ 22b. DATE SIGNED 5/10/66 22o. SIGNATURE ATTENDING 139 DIRECTOR director, poge should be filed Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal. M. Sykesville. Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (Stote) B REMOVAL (Specify) 5/13/66 Hampstead Cemetery Hampstead, Md.

SISTRAR | 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 NA Ullrich Funeral Home 4210 Belair Road Ochania

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	1 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYL	AND
ي ۔	- FVB	06769 CERTIFICATE OF DEATH	762
hours after death	e funeral 1 and 2 er death	1. PLACE DF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence a. STATE Maryland b. COUNTY	before admission)
s afte	aft aft	b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TDWN (if outside corporate limits, write RURAL and give	nearest town)
non	F .2	Sykes ville 9yr, 3mo, 4das Baltimore City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e.	IS RESIDENCE
24	filled paper In 72	Call and the control of the control	ON A FARM?
within	completely filled ve carbon papers event, within 72	3. NAME DF First Middle Last 4. DATE Month Day DECEASED (Type or print) Edward Gilbert Kemper DEATH May 3	Year 1966
ecuted	and comple emove car any event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IFUNDER1 YEAR last birthday) Months Oays Widdle White Widdle DIVORCED 8-27-23 42 yrs.	Hours Min.
be ex	ician a	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY Maryland 12. CITIZEN C COUNTRY Waryland	?
cate	a physical	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
it.	E E	August A. H. Kemper Katherine E. McNeal	
ath ce	attendir rmit. T 1, or rer	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) no Racords of Springfield State Hospit	tal
PHYSICIAN: The law requires that the death certificate be executed within	tian. d by the at transit pern cremation,	Life Called Dr. Drafti. Endowant and governor life for (a) (b) and (a)]	RVAL BETWEEN ET AND DEATH
res that	the hospital or attending physician. this certificate has been signed by detached for use as the burial-tran e Dept. of Health prior to burial, cre	Conditions, if any, which DUE TO Fecal impaction Wee	ks
v requi	ttending p has been as the b prior to b	gave rise to Immediate cause (a), stating the underlying cause last.	
The lav	ial or atten ificate has for use as Health pric	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TEXTING CONDITIONS CONTRIBUTING TO DEATH	WAS AUTOPSY PERFORMED?
ICIAN:	certificate certificate for use to the for use of the alth	2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 work 20f. (City or town) (County) 20f. (City or town)	(State)
ATTENDING	er :: Per	21. I certify that (I) (this hospital) attended the deceased from 1=29-5 (, 19 , to 5-3-00 , 19 , the saw the deceased alive on 5/3 and that death occurred at 1954 and that death occurred a	at (I) (we) last e stated above
S. S.	Be ge	22a. SIGNATURE M.D. ATTENDING MED. STAFF M.D. PHYS. DIRECTOR PHYS. STAFF 5-3-66	INED
O HOSPITAL	Page 4 may O FUNERAL I director, pag should be fill	22c. PMYSICIAN'S NAME (Type) Samuel P. Wise III, M.D. Springfield State Hospital	
TO HO	Page TO FUN direct should	Burial, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Burial (Specify) May 5, 1966 Moreland Memorial Park Balto. Md.	(State)
	R A15 (4)	24. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Baltimore St. DATE 5 1966 Policyles J.	ATURE
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/ 1.	PLACE OF DEATH	4		CERTIFICAT	E OF DEAT			(16763
	a. COUNTY Carrol	1		MARYLAND	Marylan	d	b. CDUN	rroll	ence before admission
	write RURAL	N (if outside corporation and give nearest tow	te limits, m)	c. LENCTH DF STAY IN 1b	c. CITY OR TOWN (If outside co	rporate limits, wr	ite RURAL and	give nearest town
	d. NAME OF HOS			nospital, give street address	d. STREET ADDRES			00	e. IS RESIDENC DN A FARM?
3.	NAME DF DECEASED	FI	rst	Middle	Last	14. DATE	Month	h [Day Year
5.	(Type or print) SEX	6. COLDR DR RACE	7. MARRIED	Alexander NEVER MARRIED	King 8. DATE OF BIRTH	DF DEAT		26	1966 EAR IF UNDER 24 HR
	Male	White	WIDDWED		9-28-80			Months Day	
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13.	FATHER'S NAM			Oznaciowa:	14. MDTHER'S MA	IDEN NAME		0,00	
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(Y.	s, no, or unkown) nknown	EVER IN U.S. ARMED FO (If yes give war or dates o	f service) 2]	12-32-1431	Springfield	d Hospi	tal Reco		
		DEATH [Enter only on ATH WAS CAUSED BY IMMEDIATE CAUSE	: 9/1	line for (a), (b), and (c). 1	i Heart de	Bead		IN D	NTERVAL BETWEEN DISET AND DEATH Years
	420	O DUE	4//						77
	Conditions, If	immediate ((b) my	mysoma					Years
_	cause (a), st underlying caus	e last.	(c)			10.8			
CERTIFICATION	PART II. OTHERS	ICNIFICANT CONDITIO	ONS CONTRIB	UTING TO DEATH BUT NOT REL	ATED TO THE TERMINAI	DISEASE CON	DITION CIVEN IN I	14.00	19. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTI	WAS UNDERLYING ☐ NG ☐ CAUSE OF DEA IFY MEDICAL EXAMI	TH	DESCRIBE HOW INJURY OCC	URRED. (Enter nature	of injury in P	art I or Part II o	f Item 18.)	
MEDICAL	20c. TIME DF I Hour a.m		Year 20d. t While at wor	Not While fact	ACE OF INJURY (Home, ory, street, office bldg.,	farm, 20f. etc.)	(City or town)	(County)	(State)
			ital) attend	ed the deceased from	May 11 ,	19 66 , to.	May 26		that (X(we) las
	saw the dec	eased live on	May 26	19 00 , and tha	at death occurred at	130 M, fr	om the causes	and on the d	date stated above
	22a. SICNATUR	E				MED	PTACE	1	-111
		Small On	mM	<i>D</i> . M.		MED. DIRECTOR	STAFF PHYS.	5-6	26-66
	22a. SICNATUR 22c. PHYSICIA NAME (Ty	Groff On	M SEI	SER MID,	D. ATTENDING PHYS. 224 ADDRESS	DIRECTOR [phys. V	wille,	16-66
23a	22c. PHYSICIA NAME (Ty	N'S PPO ERNEST ATION, 23b. DATE 1 CITY 5-31	BEI THEREOF - 66		D. PHYS. 22d ADDRESS 11 May 16	Mole b	PHYS. IN CATION (City, to	wille,	Md

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH executed within 24 hours after death funeral 1 deota 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland o. COUNTY Carroll MARYLAND Baltimore City ond in any event, within 72 hours after filled in by the fu papers. Pages 1 b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Baltimore 8yrs.10mos.2dvs. Sykesville papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2002 Park Avenue Springfield State Hospital YES NO TO 3. NAME OF Middle ician and completely fleose remove carbon First 4 DATE Lost Month Doy Year DECEASED HELEN CONSTANCE KLEIN (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In veors 7. MARRIED NEVER MARRIED lost birthdoy) Months Days Hours Female White WIDOWED DIVORCED 5-3-14 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT **INDUSTRY** COUNTRY? attending physician sermit. Then pleose Maryland

14. MOTHER'S MAIDEN NAME requires that the death certificate ILS.A 13. FATHER'S NAME burial, cremotion, or removol, Thomas Baran Frances (last name unk. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) permit. Records. Springfield State Hospital Unk. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) Gastrointestinal hemorrhage DUF TO Uremia Conditions, if ony, which gove Months rise to immediate couse (a). DUE TO stating the underlying cause prior ta b Page 4 may be retained by the hospital or attending os the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS associated with convulsive disorder, with psychotic reaction 19. WAS AUTOPSY PERFORMED? TO FUNERAL DIRECTOR: After this certificate has be detoched for use State Dept. of Heolth CERTIFICATION NO K 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) (Stote) Not While foctory, street, office bldg., etc.) ot work ot work and that death accurred at 8:50 21. I certify that (I) (this haspital) attended the deceased fram. 19____, that (I) (we) last director, page 3 should should be filed with the 3 should Marrom causes and on the date stated above. saw the deceased alive on_ 5-5-66 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. 5-5-66 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Antonius Glahm, M. D. NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) RESUILLE 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1966 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death. funer and PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) etely filled in by the bound of write BURAL and give nearest town) hours manchester mil d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO G YES etely executed within carbon NAMEROF First Middle Last 4. DATE Year Month Day DECEASED event, compl (Type or print) DEATH 1966 5. SEX етоме 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IIF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Months Davs Hours and WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT Al. BIRTHPLACE (County & State, or foreign country) an during most of working life, even if retired) death certificate be INDUSTRY COUNTRY? A FATHER'S NAME MOTHER'S MAIDEN NAME attending rmit. Th rem 15. WAS DECEASED EVER IN U.S. ARMED FORCES? SOLAL SECURITY NO. INFORMANT Address 0 (Yes, no, or unkown) (If yes give war or dates of service) 4 cremation, the pen 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN law requires that the signed by urial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: hospital or attending physician. IMMEDIATE CAUSE (a) the burial, the bu DUE TO Cenditions, If any, which (b) gave rise to immediate DUE TO (a), stating the as th underlying cause last. has (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY this certificate betached for use to Dept. of Health use PERFORMED? YES [NO 🖂 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 1 20f. (City or town) (State) (County) be de State i After tould be the state of the factory, street, office bldg., etc.) Hour a.m. While Not While 19 at work at work retained 195) 21. I certify that (1) (this hospital) that (A)7(we) last attended the deceased from shoul and that death occurred at 4 4 M. from the causes and on the date stated above. DIRECTOR saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED pe page ATTENDING MED. STAFF M.D. PHYS. DIRECTOR PHYS pa FUNERAL HOSPITAL 22C. PHYSICIAN'S **ADDRESS** irector, p 22d. NAME (Type) pinous BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town or county) (State) ᇹ REMOVAL (Specify) 2 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) 20M 1/65

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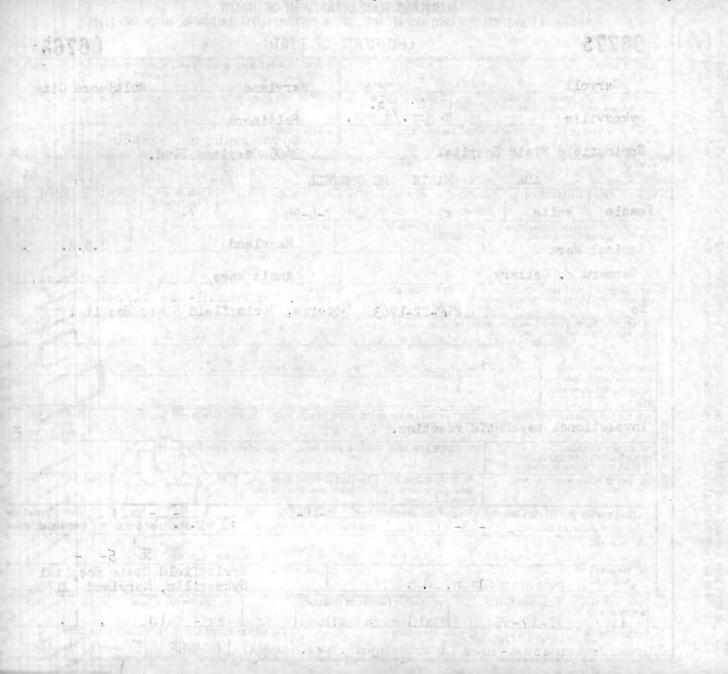
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	14	1	06773 CERTIFIC	ATE OF DEATH		06766
eath	nd nd eath	ı	I. PLACE OF DEATH		E (Where deceased lived, if instit	rutian: Residence befare admission)
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, with	arbai nt, w	M	DECEASED (Type or print) MARY Florence	Ludwig	OF DEATH 5	19 19 66
ecuted	and campletely filled in by the funeral semave carban papers. Pages 1 and 2 in any event, within 72 haurs after death		5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED [Female White WIDOWED DIVORCED [8. DATE OF BIRTH	9. AGE (In years last birthday)	Manths Days Hours Min.
e &	and rem n an	1	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR		inty & State, ar fareign country)	12. CITIZEN OF WHAT
te b			during mast of warking life, even if retired) INDUSTRY	MARY	land	12. CITIZEN OF WHAT COUNTRY?
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cert	구 등 S		Thomas Wilson	Selbi	y Bull	
# #	it.]		IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, np, grunknawn) (If yes give war ar dates af service)	17. INFORMANT	Add	dress
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hat the	i pnysician. signed by the attending prive burial-transit permit. Then- i burial, crematian, ar remaval		1B. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIV	E HEART	- FAILURE	INTERVAL BETWEEN ONSET AND DEATH
÷ se	od by		4300 DUE TO		11.	1000
quir	phys signe surio surio		(b) ARTERIO SCA	EROTIC	HEART DIS	EASE YEARS
. v	he the track		stating the underlying cause last. (c)			
<u>o</u>	endles be as to as		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE	D TO THE TERMINAL DISEASE	CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
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O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death	Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta		20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU CIFETHER, NOTIFY MEDICAL EXAMINER)	RRED. (Enter nature af injury	in Part I or Part II of item 18.)	
PHY:	the har this ce detach e Dept		20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20 While Nat While	e. PLACE OF INJURY (Hame, f factory, street, affice bldg., e		(Caunty) (State)
NIC.	by ffer be Stat		21. I certify that (I) (this haspital) attended the deceased fro	m 5/18	1966 to 5/1	19 , 1966, that (I) (we) last
I I	R: /		saw the deceased olive an 5/19 1966, and	that deoth occurred	at 8 M, from cause	s and an the date stated above.
R AT	RECTO 3 shot		220. SIGNATURE	M.D. PHYS.	MED. STAFF DIRECTOR PHYS.	22b. DAJE SIGNED 5/19/66
ITAL 0	nay be	1	22c PHYSICIAN'S NAME (Type) Windent Fincen T	R 22d. ADDRESS	minster D	nd.
HOSP	UNE UNE ector auld		23g BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETER	Y OR CREMATORY	23d. LOCATION (City or 1	1)
5,	10 F P P P P P P P P P P P P P P P P P P		REMOVAL (Specify) 5-22-66 New OA	Kland Cemete	REY SUKESVII	REGISTRAR'S SIGNATURE
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32 MAY S. A. 1300 Your South Surger

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06774 executed within 24 haurs after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY a. COUNTY a. STATE Carroll Maryland MARYLAND and in any event, within 72 hours after c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, Rural-Sykesville 7m. 9d. Baltimore e. IS RESIDENCE ON A FARM? rsician and completely filled in please remave carban papers. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS 1810 Hope Street Springfield State Hospital YES NO E 3. NAME OF Middle DATE Manth First Day Year DECEASED Gabriella 66 Masopust 19 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED last March 1885 birthday) Manths Days Haurs female white WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during mast of warking life, even if retired) INDUSTRY COUNTRY? attending physician permit. Then please USA Austria requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, ar removal, Joseph Panek Sodek 17. INFORMANT 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no. or unknown) (If yes give war ar dates af service) Springfield Hospital records, Sykesville none INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH Arteriosclerosic cardiovascular disease IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DHE TO Generalized arteriosclerosis Canditians, if any, which gave years rise to immediate cause (a). DUF TO as the priar to b stating the underlying cause has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION Schizophrenic reaction, hebephrenic type. NO DE this certificate P 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) (City or town) (County) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.) Haur a.m. **Nat While** at wark at wark 10/16/_ 19 20 BOM 5/25/, 1966, that (We) last 21. I certify that (this haspital) attended the deceased fram. and that death accurred at 3:00 M, from causes and an the date stated above. 1966 FUNERAL DIRECTOR: 5/25/ saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING 5/25/66 X M.D. DIRECTOR PHYS. director, page shauld be filed Springfield State Hospital Sykesville, Maryland 22d. ADDRESS 22c. PHYSICIAN'S J. Arribas. M. D. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City ar Tawn) (County) 23a. BURIAL, CREMATION 23b. DATE THEREOF (State) REMOVAL (Specify) reedom 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE **SUMERAL DIRECTOR** Charles 1966

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06775 CERTIFICATE OF DEATH executed within 24 haurs after death. completely filled in by the funeral nave carban papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) deal o. COUNTY g. STATE b. COUNTY Carroll MARYLAND Baltimore City b. CITY OR TOWN (If outside carporate limits, C LENGTH, OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) van papers. Pag within 72 haurs Sykesville mos. Bal timore IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRE 5506 Stonington Avenue Springfield State Hospital 3605 Garrison Blvd YES NO 3. NAME OF First Middle Lost Doy Year DECEASED OF May 19 66 ADA MARIE MC CONNELL (Type or print) DEATH S. SEX B. DATE OF BIRTH AGE (In years IF UNDER YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remave birthdoy) Months Hours Female White WIDOWED & DIVORCED and in any 7-4-94 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT please INDUSTRY U.S.A attending physician permit. Then please requires that the death certificate Marvland Clerical Work 14. MOTHER'S MAIDEN NAME ar remaval, Bernard F. Gallery Annie Ross Frederick, Md IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Agnes M. McConnell-234 Carroll Pkwy permit. (Yes, no, or unknown) (If yes give wor or dates of service) Records. Springfield State Hospital INTERVAL BETWEEN ANSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line, for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: in 1 la IMMEDIATE CAUSE (o) by DUE TO arterioselerote CKD Conditions, if any, which gove rise to immediate couse (a), DUE TO O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) INVOLUTIONAL psychotic reaction. 19. WAS AUTOPSY PERFORMED? NO YES [P 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased fram___ 8-18-59 to 5-13-66, 19..., that (I) (we) last . 19 shauld and that death occurred at 9:30 MPFeomerouses and on the date stated above. 5-13-66 saw the deceased alive on_ 19 22g. SIGNATURE 22b. DATE SIGNED 5-14-66 DIRECTOR directar, page should be filed Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Antonius Glahn Sykesville, Maryland 21781 23o. BURIAL, CREMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) (County) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF Baltimore National Cemetery - Baltimore, Md. 5-17-66 Buria. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL QUECTOR Ochanles Judge 16 DATEMAY 1966 Ellsworth Armacost-4600 Liberty Hghts. Ave. 20 M 1/66



1.3		Division	of STATISTIC	MARY AL RESE	LAND STATE DE	PARTMENT OF			F 1 MAR	YI AND
FOR STATE		06776		EDICAL		CERTIFICAT		DEATH		06769
HEALTH DEPT.	(1.	PLACE OF DEATH		Item	23b Film G37		CE (Where I			dence before admission
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cessary, the funeral 5 may be Department of the death.		b. CITY OR TOWN (I write RURAL and	f outside corporate	e limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (I		orporate limits, wr	Ite RURAL an	d give nearest town
cessi may may partm		Sykesvi	110	71.0	3mos.19dys.	Rural - F		tone	0 1	1-2
Depa after					ospital, give street address)	d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?
and 3 to 1 sage 3. Page 5 state D hours at	-		eld State			Rt. #1				YES NO
my del M3. M3. T2 ho	3.	NAME OF DECEASED	Fir AMA		Middle MAR	MEANS	4. DAT		3	Day Year 19 66
200	5.	(Type or print) SEX 6.	COLOR OR RACE			8. DATE OF BIRTH			IF UNDER 1 Y	(EAR) IF UNDER 24 HRS
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nief hief		couse (a), stetir underlying cause is	The bill of	(c) CV	sold sold	The soid	Sil	esode	2	
ficate shoulthe word the word the Chief used as a to burial,	NOI	PART II. OTHER SIEN	IIFICANT CONDITIO	NS CONTRIBU	TING TO DEATH BUT NOT REL	TED TO THE TERM WAL	DISEASECO	NDITION GIVEN IN	PART 1(a)	19. WAS AUTOPSY PERFORMED?
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certif riting ded to ald be prior	CERTIFICATION	20a. EXTERNAL CA PRIMARY OF OF CON CAUSE OF DEATH.	AUSE WAS	20b. [DESCRIBE FOW INJURY OCCI	IRRED. (Enter nuture o	f injury in	Part I or Part II o	f Item 18.)	
wri ward vard noule		20c. TIME OF INJU		foor Lood II	NJURY OCCURRED 200. PL	CE OF INDURY (Home, f	201	(City or Jown)	//County	y) (State)/
EXAMINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form files. Files. Files. Files a should be used as a burial-transit permit. File pages 1 and 2 with designated agent, prior to burial, cremation, or removal, and in any event within	MEDICAL	Hour a.m.	3/16	1 /	facto	ry, atreet price blog.,	etc.)	ceken	Who C	sus a bik
the certific should be r files. CTOR: Page designated	Σ	p.m.	at took charge	of the rem	ains described above, he		Inspect	ion V. Inqu	iry 🗆	and In my opinion
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	DIVISION OF STATISTICAL R		TE OF DEAT		Centro
-	LACE OF DEATH		2. USUAL RESIDEN		stitution: Residence before edmissi
1	Carroll	MARYLAND	a. STATE Mary	ь. count yland	Y Carroll
	CITY OR TOWN (if outside corporate limits, write RURAL and give neerest town)	c. LENGTH OF STAY IN 16		If outside corporate limits, write I	
-	Westminster RD #3	62 years		ter RD #3	06-1
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3	NAME OF First DECEASED	Middle	Last	4. DATE Month	Dey Yeer
	Type or print) JAMES	LUTHER MEN		DEATH May	10 1966
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	farmer			Co., Maryland	U.S.A.
	FATHER'S NAME		14. MOTHER'S MAIDEN	NAME	
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	19 GEVICE OF BELLEVIE	218-14-6265	rs. Grace K	Coontz Menchey	same
	18. CAUSE OF DEATH [Enter only one cause PART I. DEATH WAS CAUSED BY:	A LIT	P. 1.		ONSET AND DEATH
	IMMEDIATE CAUSE (e)	190 cardial +n.	tarction		acute
ı	4 de / DUE TO	1	. 6	1 000	
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	PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT AN	T DELATED TO THE YERM	NAL DISEASE CONDITION CIVE	NIN BART 1/-) IS WAS AUTORS
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	206. ACCIDENT WAS UNDERLYING 206. OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	D. (Enfer nature of injury in	n Perf I or Perf II of item 18.)	
		20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, fare	m, ! 20f. (City or town)	(County) (State)
4 - 1 - 1 - 1	Hour a.m.	While Not While fac	ory, streat, office bldg., etc		(County) (Stote)
	print 17	t work at work		10 1 1	
	21. I certify that (I) (this hospital) a				
	saw the deceased alive on April		death occurred at //.	MAM, from the causes an	
	22a. SIGNATURE	11.11	Dunie III	MED. STAFF	22b. DATI SIGN
	220 PHYSICIAN'S	MUN M	.D. PHYS. 22d. ADDRESS	DIRECTOR PHYS.	
	NAME (Typo) IP W. ME.	ROFP	WINAIN	ST WESTM	INCTED MA
-	BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY		123d. LOCATION (City, town	
ľ	EMOVAL (Specify) 5/12/66	Leister's		Westminster	
-	burial 17/12/00	ADDRESS		C'D BY REGISTRAR 256. REGI	
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Items 18821 Film G37 MARYPAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE b. COUNTY Carroll MARYLAND Maryland Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give hearest town) Maryland funeral may be Department after death. b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 1b write RURAL end give nearest town) Silver Spring Sykesville lmo.27dvs. the d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ge to State 12/11 Atherton Drive Springfield State Hospital NO FE YES NAME OF First Middle DATE Month Year DECEASED the FRANKLIN (MMN) METZLER (Type or print) DEATH MAY 19 66 2 with within 6. COLOR OR RACE | 7. MARRIED T NEVER MARRIED 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. lest birthdey) Months | Devs Hours White 9-16-27 Mala WIDOWED DIVORCED and a 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12, CITIZEN OF WHAT Give COUNTRY? Masseur New Jersev U.S.A any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME = Franklin Metzler Sceola Broome File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, 110, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. | uted within ? "in pencil in Examiner's Unk. Records, Springfield State Hospital 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) burial-transit Bilateral bronchopneumonia Day cremation, DUE TO Complete diagnosis pending toxicology examination Conditions, if any, which icate should be e the word "pend the Chief Medic (h) gave rise to immediate Poisoning due to lethal dose of Doriden day or more DUE TO (a), stating the co. used as a to burial, underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY CERTIFICATION PERFORMED? YES W NO T the certificate, writing the should be forwarded to or or 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 3 should bagent, price MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home. farm. (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) factory, street, office bldg., etc. Hour a.m. Not While CTOR: Page designated at work at work and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry DIRECTOR: Natural causes Accident Homicide Undetermined manner death resulted from: Suicide / # 1/. CHIEF MEDICAL EXAMINER 4 for your ASSISTANT MEDICAL EXAMINER SIGNATURE 50 DEPUTY MEDICAL EXAMINER **EXAMINER'S** director. W. Glenn Speicher. M.D. harres soulles was albertus NAME (Type) LOCATION (City, town or county) DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. BURIAL, CREMATION, 23b. REMOVAL (Specify) Zion emetery 0 Ta. Coventry 24. FUNERAL DIRECTOR ADDRESS 1966 VR ALSME (5) 1/65

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

OF 779

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1.	PLACE OF OEAT	H			11	2. USUAL RESIDE	NCE (Wh	ere deceasi			esidence	before ad	mission)
	Carr	077		MARYLA	NID.	a. STATE Maryl	and		b. COUN	roll			
	b. CITY OR TOW	N (if outside corpora and give nearest tov	te limits,	c. LENGTH OF STAY II		c. CITY OR TOWN (e corpor			end glv	e neares	t town)
	Rura	al Finksbur	g	Lifetime		Rural -	Fin	ksbu:	rg		0	6-1	
	d. NAME OF HO	SPITAL OR INSTITUTION	ON (if not in h	ospital, give street add	ress)	d. STREET AOORES	S				0	. IS RES	DENCE
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3.	NAME OF DECEASED		rst	Middle		Lest	1 0	ATE OF	Month		Day	Yea	
-	(Type or print)	Henry		Α.		ller	1	EATH	May		15	196	
Э.	SEX	6. COLOR OR RACE	7. MARRIEC	NEVER MARRIEO		DATE OF BIRTH	910	9. At	GE (In years st birthday)	Months	0avs	Hours	24 HRS.
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		,	Par	contrac Bldg		Carı	coll	Co.,	Md.		J. S		
13.	FATHER'S NAM	E		001102 110 002	1	4. MOTHER'S MA	IDEN NA	ME					
	Richa	rd Miller				Myrle	Max						
15.	WAS OECEASED I	EVER IN U.S. ARMED FO	RCES? 16.	SOCIAL SECURITY NO.	17. IN	FORMANT	e Mar	in_	Addres	SS			
(16	s, no, or unkown)	(If yes give war or dates o	2.	16-14-5926	Ma	oc Posth N	/÷ 7 7 -		The sales	1	26.3	-	
-		DEATH [Enter only on	e cause per l	line for (a), (b), end (c).		cs. Ruth M	TTTTE	r	Finks	sourg,	MO	VAL BET	WEEN
		ATH WAS CAUSED BY										T ANO C	
-	1 100	IMMEDIATE CAUSE	(a) Gene	ralized Ade	eno-c	earcinomat	osis				_Ap	p. 2	Yrs.
	15 4	DUE									-		
	Conditions, If gave rise to		(b) Prim	ary mucinous	s ade	eno-carcir	noma	of r	ectum_				
	cause (a), st	tating the DUE	TO										
z	underlying caus		(c)										
CERTIFICATION	PART II. OTHER S	SIGNIFICANTCONOITI	ONS CONTRIB	UTING TO OEATH BUT NOT	TRELATE	D TO THE TERMINAL	DISEASI	CONDIT	ION GIVEN IN I	PART 1(a)		WAS AU	
Ĕ	20a. ACCIDENT	WAS UNDERLYING	20b.	OESCRIBE HOW INJURY	OCCURR	FO. (Enter nature of	of injury	In Part	or Part II of	f Item 18.		, [10 171
SE	OR CONTRIBUTI	ING CAUSE OF OFA	TH		00001111	Los (Littor Hataro	oju.,						
		INJURY Month, Oay,		INJURY OCCURRED 206	e. PLACE	OF INIURY (Home,	farm.l 2	Of. (CII)	y or town)	(Cou	ntv)	(S	tate)
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		y that (I) (this hosp beased alive on	May	led the deceased from	m_JUI	eath occurred at	8:30	, to_Ma	the causes	, 19 <u>66</u>	, thate	et (I) (w stated	above.
	22a. SIGNATU		1	1/4				.,		22b. 0/	TE SIG	NEO/	
	1	sep///	S.	shl/h	M.O.	ATTENDING PHYS.	MEO. OIRECT	OR 🗍	STAFF PHYS.	51	16	166	
	22c. PHYSICIA	N'S	1	or our	401	22d. ADDRESS	OINLOI		11110.	1			
	NAME (T)	Josep	h E. B	ush, M.D.		Hampst	ead.	Mary	rland 2	1074			
23a	BURIAL, CREM	ATION, 23b. OATE	THEREOF	23c. NAME OF CEM	ETERY O				TION (City, to		nty)	(Sta	ate)
6	Buria.	1 ^{clfy)} 5/18	166	Wesley	Came	terv		C	arroll	Co			Md.
24.			, , , ,	ADDRESS	- OLIT	25a RI	EC'D RY	RIGEE	AR 250 RE	GISTPAR	GIGNA	TURE	KAMA_
1	dipton-	Eline	Ha	empstead,	Md.	DATE	20	1300	- July	nas	June		

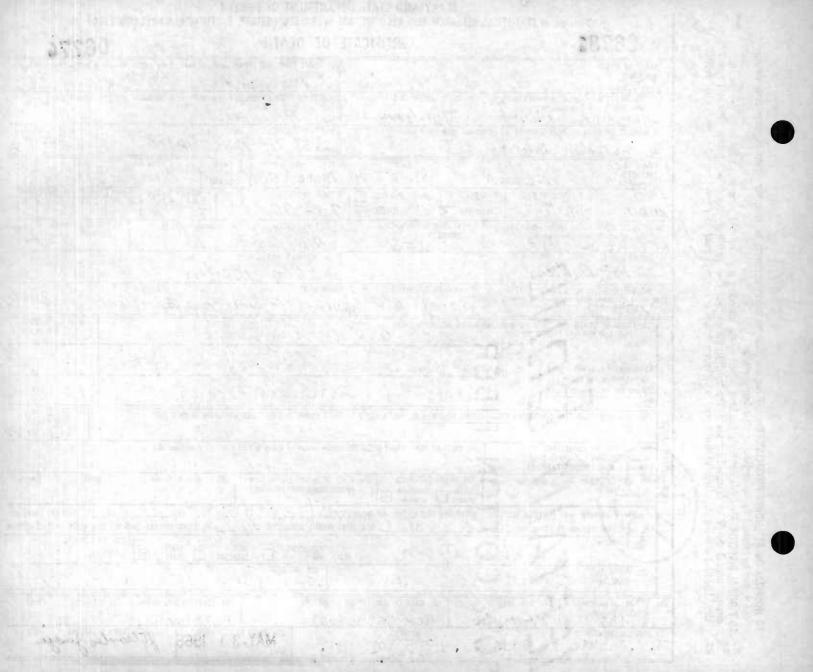
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decaased lived, If institution; Rasidence before admission) a. COUNTY Page b. COUNTY Carroll MARYLAND Marvland Carrol 1 b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) ō Tanevtown Tanevtown d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS . IS RESIDENCE ON A FARM? retained ne State E YES NO W Taney Drive anev Drive 3. NAME OF First Middla DATE Day Month Van DECEASED OF (Typa or print) Gertie Benla DEATH 19 66 Mover Mav 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9 AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Days Hours Femal a White DIVORCED [WIDOWED T 2, 1885 10a. USUAL OCCUPATION (Giva kind of work 1Db. KIND OF BUSINESS OR INDUSTRY I 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if ratired) Housewife Own home Allentown, Penna. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Franklin Kramer Annie Lembach 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yas give war or dates of servica) along with transit permit 71-05-2635 Mr. Wilbur Moyer. Taneytown, Maryland 1B. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).] INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Office DUE TO Conditions, if any, which (b) gava rise to immadiata causa 603 DUE TO (a), stating the undarlying causa last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO pinous 20a. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INJURY OCCURAD. (Enter nature of Injury in Part I or Part II of itam 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 900 MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stata) factory, street, office bldg., atc.) While Not While at work at work prior DIRECTOR 21. I certify that I took charge of the remains described above, held an Autopsy Inspection | Inquiry end in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED should be for FUNERAL I SIGNATURE DEPUTY MEDICAL EXAMINER 49 Frederick St., Taneytown, Ambler Thompson. M.D. NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stata) REMOVAL (Specify) 040 0 Burial . 1966 Greenwood Cemetery Allentown. Penna. 24a. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. A15ME C.O.Fuss & Son(John H. Skiles Taneytown, Md. 5M 7/59

SELECTION SELECTION and the second s The state of the second of the state of the A 18 Louis Land Ask and Carlotte Later 1 Later 1 Land the entropy of the en bortal in a little Creammand Commence Libertone, Santa C.O. Shar E Detailonn I. Carles Tenevious, Ed. MAV S I 1985 John De Proper

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05781 CERTIFICATE OF DEATH within 24 hours after deoth. by the funeral Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. CQUNTY h COUNTY physician and completely rinea in 27 pers 1 en please, emove corban papers. Pages 1 ovol. and in any event, within 72 hours after Arroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neorest town) BAltimore 6 mos. 22 de d. STREET ADDRESS IS RESIDENCE ON A FARM? OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) YES NO NAME OF First Middle 4. DATE Month Year Day DECEASED 19 (Type or print) DEATH requires that the death certificate be executed S. SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost_birthdoy) Months Dovs Hours 7-13 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
RETIRED-Clerk COUNTRY? INDUSTRY 11.S.A. SALE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, or removol INFORMAN) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address signed by the ottendii burial-tronsit permit. 1 records, Sykesville (Yes, no, or unknown) (If yes give wor or dotes of service) 13-07-1 INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o' Page 4 moy be retained by the hospitol or ottending physician. DUF TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO Years stoting the underlying couse O FUNERAL DIRECTOR: After this certificate hos been 3 shauld be detoched for use os the with the State Dept. of Health prior to WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION NO YES 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (Caunty) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While 19 ot work 21. I certify that (I) (this haspital) attended the deceased fram lay ta. , and that death accurred at// 53 saw the deceased alive an_ M, from causes and on the date stoted obove Ot y 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS. director, page 3 should be filed v M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial ew Cathedra Baltimore ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/68 Co. 4905 York H.W.Jenkins & Sons



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06799 OCHHE CERTIFICATE OF DEATH

00000	CERTITICATE	OI DEATH		000	()
1. PLACE OF DEATH			(Where deceosed lived, if institut	tion: Residence bef	fore odmission)
o. COUNTY Carroll	MARYLAND	o. STATE Marylan	b. COUI	NTY	
b. CITY OR TOWN (If autside carparate limits,	c. LENGTH OF STAY IN 16	CITY OR TOWN //	utside carparate limits, write RU	DAL and also son	2 d A
Rural Sykes ville	C. LENGTH OF STAY IN 10			KAL and give near	est town)
	Byr. 9 mo.		Lewisdale	1500	7
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspit	al, give street address)	d. STREET ADDRESS		1000	e. IS RESIDENCE ON A FARM?
Springfield State Hosp:	ital	Route #	4 1		YES NO X
3. NAME OF First DECEASED	Middle	Lost	4. DATE Mont	th D	oy Year
(Type or print) Nora	Melissa Mus	grove	DEATH 5	19	1966
S. SEX 6. COLOR OR RACE 7. MARRI		DATE OF BIRTH	9. AGE (In years	IF UNDER 1 YEAR	
Female White WIDOW	ED DIVORCED	3-16-97	last birthday)	Months Days	Hours Min.
	. KIND OF BUSINESS OR		y & State, ar fareign country)	12. CITIZEN	OF WHAT
during most af warking life, even if retired)	INDUSTRY			COUNTRY	USA
Housewife		Maryland			ODA
13. FATHER'S NAME		14. MOTHER'S MAIDEN			
William A. Beall			Watkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, arunknawn) (If yes give war ar dates af service)	16. SOCIAL SECURITY NO. 17. IN	NFORMANT	Addre	ess	
no	none Spr	ingfield H	lospital recor	rds, Syk	resville
1B. CAUSE OF DEATH (Enter anly one cause per line	far (a), (b), and (c),)			1 11	NTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	Suppurative nephr	ritie hila	teral organie	m (Days Death
7/5 X IMMEDIATE CAUSE (a)	Apparautve nepni	TOTOS OLIC	ocrare organis	All	Days
Can distance if any sublish same a	ınknown.			100	
rise to immediate couse (a)	HIRHOWII	10111111			
stating the underlying cause DUE TO	re				T-T la-
	Infected decubitu				Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION	IG TO DEATH BUT NOT RELATED TO TH	HE TERMINAL DISEASE CO	NDITION GIVEN IN PART 1(0)	19	9. WAS AUTOPSY PERFORMED?
ATIC					YES NO
200. ACCIDENT WAS UNDERLYING 20b OR CONTRIBUTION 20b OF CONTRIBUT	DESCRIBE HOW INJURY OCCURRED. (I	Enter nature of injury in	Port I ar Part II of item 18.)		
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Manth, Day, Year 20c	d. INJURY OCCURRED 20e. PLACE	E OF INJURY (Home, form	m. 20f. (City or town)	(County)	(Stote)
Hour o.m.	hile Nat While facta	ry, street, office bldg., etc.		((3.0.0)
p.m. (7 gr	MOIN ALL OT MOIN	0.700			
21. I certify that (X) (this hospital) at	ended the deceosed from	8/22 ,	1957 to 5/19	19.66	that (t) (we) las
saw the deceased alive on 5/	19 66 and that	death accurred at	7:10AM, from couses		
22a. SIGNATURE		ATTENDING	MED. STAFF	22b. DATE SIG	GNED
Frances Deid	avors, M.D	. PHYS.	DIRECTOR L PHYS.		9166
22c. PHYSICIAN'S		22d. ADDRESS ST	oringfield Sta	ate Hosp	pital
NAME (Type) Frances Reid	Nabors, M.D.	Sy	kesville, Mar	ryland 2	21784
23a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY OR C	REMATORY	23d. LOCATION (City or To	wn) (Caun	ty) (State)
Burial May 21, 196	6 Montgomery M	leth.	Clagettsv	111e. M	d.
24. FUNERAL DIRECTOR	ADDRESS		D BY REGISTRAR 25b RE	GISTRAR'S SIGNA	
Olin L. Molesworth	, Damascus, Md.		2 3 1966 40	corres &	udge
		UMIE/ 1	M A 1444 //	//	

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital or attending physician.

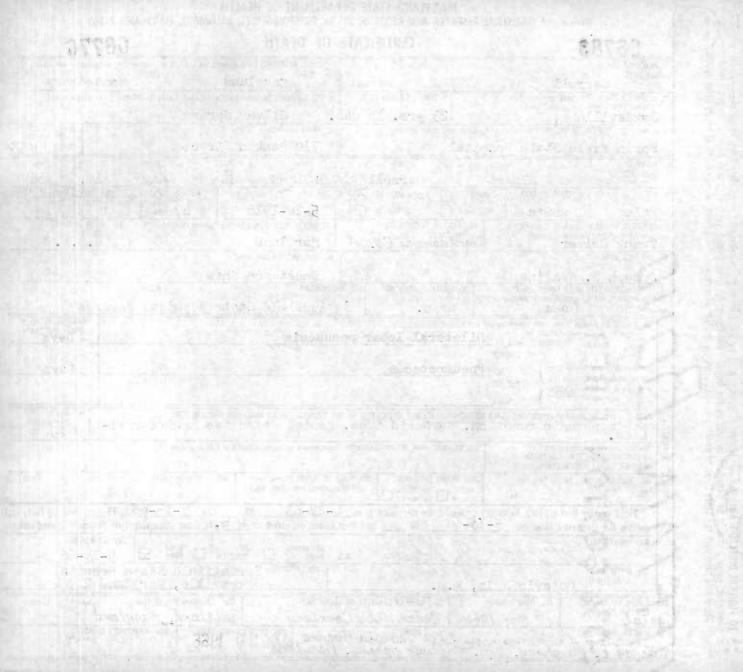
VR A15 (4) 20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please semove carban papers. Pages 1 and 5 should be filed with the State Dept. at Health priar to burial, crematian, ar remaval, and many event, within 72 haurs after death

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death puo 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY Maryland Montgomery Carroll g any event, within 72 haurs after MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

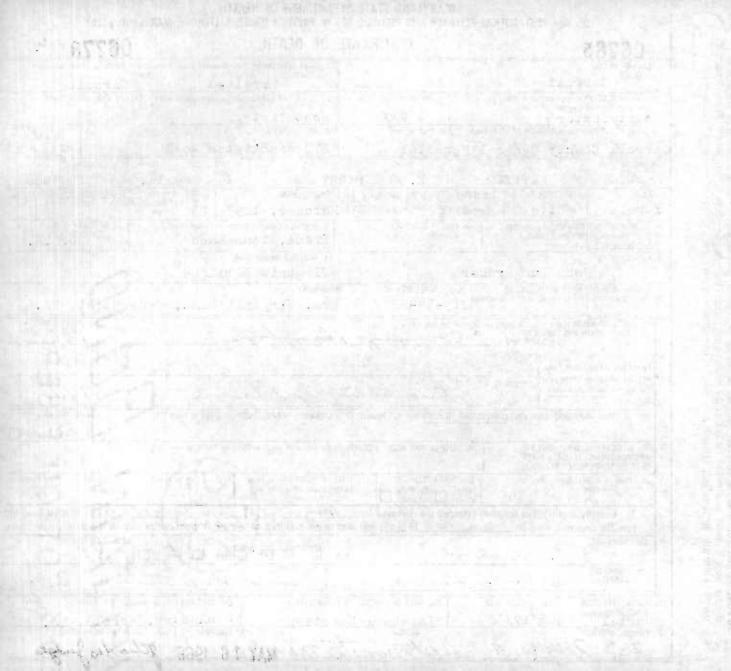
Spkesville c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 vrs./16 das. Silver Spring physician and completely filled in ten please, remove carbon papers. e. IS RESIDENCE ON A FARM? completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS 712 Hankin Street Springfield State Hospital YES NO X Middle 3. NAME OF 4. DATE Manth Year Last Day DECEASED 1966 NESLINE Albert Carroll May DEATH (Type or print) IF UNDER 24 HRS. AGE (In years IF UNDER 1 YEAR S SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) last Months Days Hours 5-20-1916 WIDOWED DIVORCED Male whi te 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) COUNTRY? during most of working life, even if retired)
Truck Driver **INDUSTRY** Montgomery Co. Maryland 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME burial, crematian, or removal Constance Shaw Joseph B. Nesline 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address burial-transit permit. (Yes, no, ar unknawn) (If yes give war ar dates of service) Springfield State Hospital Records unkn. no 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bilateral lobar pneumonia IMMEDIATE CAUSE (a) signed by Poge 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave Days Pneumococcus rise ta immediate cause (a), DUF TO stating the underlying cause this certificate has been of Health priar to far use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, paranoid type. Mental defective undifferntiated. 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES IK NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. o 20e. PLACE OF INJURY (Home, form, (City or tawn) (County) (State) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Hour a.m. Nat While foctory, street, office bldg., etc.) 19 at work FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram 4-29-43, 19, ta 5-15-66, 19, that (I) (we) last director, page 3 shauld shauld be filed with the , and that death accurred at 4 P.M. fram couses and on the date stated above. 7.5-66 19 saw the deceased alive an_ 22a, SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS. 5-15-66 M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN" NAME (Type) Sykesville, Maryland 21781 Octavio Ruiz. 23d. LOCATION (City or Tawn) 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, (County) 23b. DATE THEREOF REMOYAL (Specify) Suitland, Maryland edar Hill Cemetery Burial 9 25h REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADBRESS rgia Avenue VR A15 (4) 20 M 1/66 Silver Spring, Maryllon Dumphrey.



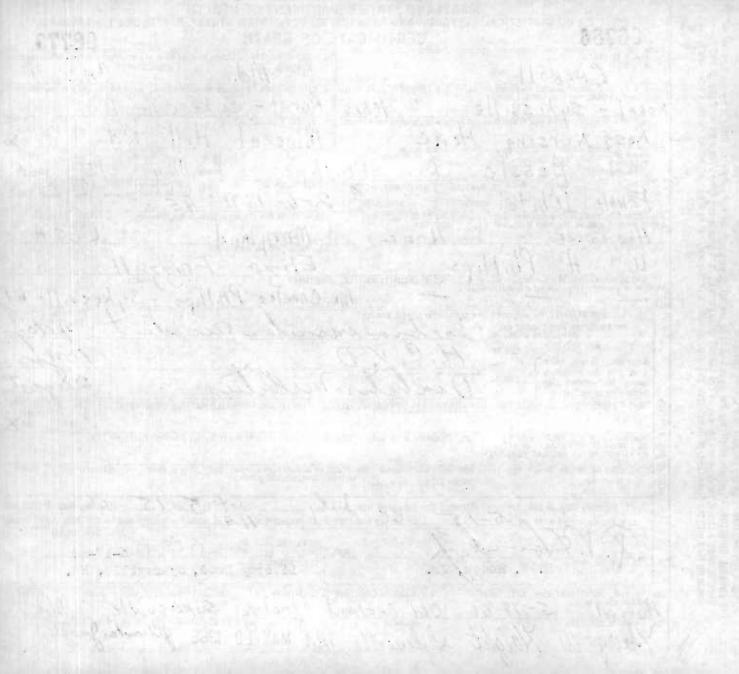
1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	06784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06777
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE.
	a. STATE ARROLL MARYLAND b. COUNTY CARROLL
o the funeral e 5 may be Department after death.	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
may may be the may may may barth	UNION BRIDGE YEARS UNION BRIDGE 06.1
De Se afte	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
Pag Pag Urs	LIGHTNER ST. YES NO X
my de Mas.	3. NAME OF First Middle Last 4. DATE Month Day Year OF OF DEATH MAY 30 19 46
PN PN	
h. If a form From Within	Markied Never Markied I williast birthday) Months Days Hours Min.
Page th the the the the the the the the the	10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State of foreign country) 12. CITIZEN OF WHAT
ter dea Give Pa Give Pa S with 1 and 1 even	during most of working life, even if retired) INDUSTRY PACK HOUSE CEMENT MARYLAND USA
ours after 18. Grand along pages 1 in any	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
hour em l ce d	EDGAR BLACK MINNIE NOKES
24 ho in Iten Office File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)
within pencil in miner's permit.	NO 212-03-7790 HELEN NOKES UNION BRIDGE
CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delease certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. ur files. EVIOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the SI designated agent, prior to burial, cremation, or removal, and in any event within 73 ho	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: ONSET AND DEATH
Existensity or 1, or	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cies on lary (tront and beath)
"he executed "peding" in if Medical Examing a burial-transit cremation, or i	Conditions is any which I
d be "per Med buria	gave rise to immediate cause (a), stating the DUE TO
ord bird hief s a a	underlying cause last. (c)
ficate sho the wor o the Chi used as to burial,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
ffica the the to	YES NO X
iting led to d be prior	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO NO NO NO NO NO NO N
R: This cer cate, writin forwarded 3 should th agent, pric	State
fer: Tor for age	Hour a.m. While Not While factory, street, office bldg., etc.)
the certificate certificate the certificate in files.	p.m. 19 at work at work 21. certify that I took charge of the remains described above, held an Autopsy , inspection , inquiry , and in my opinion
EXA ne ce shoul files. OR: lesign	death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner
EDICAL EXU ute the c ge 4 shou your files IRECTOR: its design	CHIEF MEDICAL EXAMINER
	ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 122. DATE SIGNED
	EXAMINER'S W GLENN SPFICHER Address (Stroet town for country) The world
Po Deputy Mer please execut director. Pag retained for y O FUNEAL DI of Health or i	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
dir dir	REMOVAL (Specify) 6/3/66 MT JOY UNIONTOWN MD
0	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME 35D0 4-64	DN Harlyler ysons Union Bridge DATHIN 3 1966 goliantes Judge

CCASS HAVE BE RETURNED EXEMPTING ABBREVE - 284.00 THE RELATED STATE OF THE STATE The first wall add to the many was a second to the property of the second to the secon

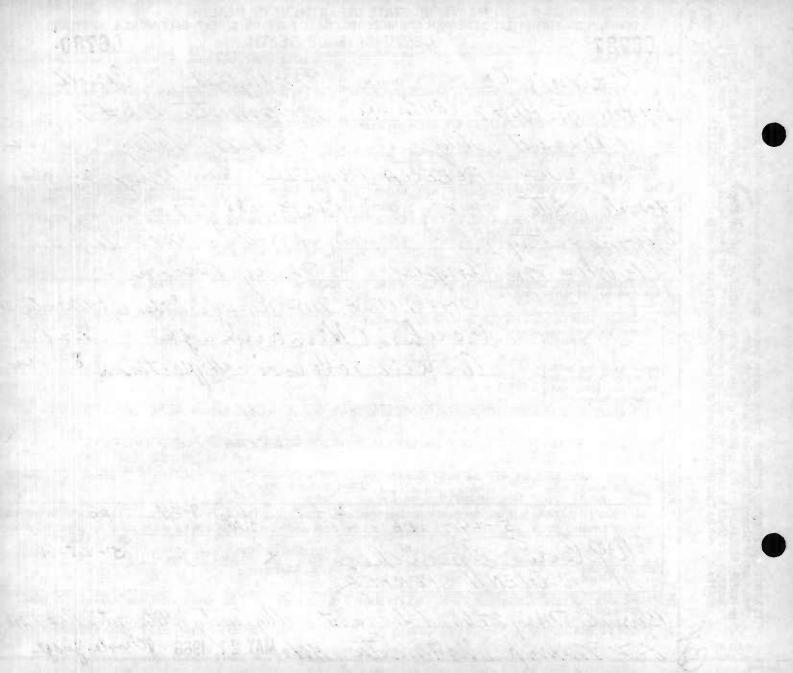
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH executed within 24 haurs after death death and campletely filled in by the funeral nave carban papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 day Westminster Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 272 Washington Road Carroll County General Hospital YES NO T 3. NAME OF Middle Lost 4. DATE Month Doy Year DECEASED PARRY 1966 NETTIE E. DEATH May 14. (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 7 dest birthdoy) emave Months Hours female white March 6, 1893 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) pe COUNTRY U.S.A. during most of working life, even if retired) **INDUSTRY** Trade, Tennessee requires that the death certificate housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME phy John Bumgardner Virginia Williams 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 215-54-2287 Mrs. Virginia Gist, Cedarhurst, Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL RETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) þ 4201 DUF TO signed Conditions, if ony, which gove rise to immediate cause (a). DHE TO stating the underlying couse attending as the has been last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION NO. O FUNERAL DIRECTOR: After this certificate the haspital or far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ... OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work of work be retained by , 19 66, ta may 14, 19 86, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram // // 1966, and that death accurred at 6 A M, fram causes and an the date stated above. shauld saw the deceased alive an_ 22b. DATE SIGNED 22o. SIGNATURE ATTENDING DIRECTOR M.D. PHYS PHYS. 22d. ADDRESS 22c. PHYSICIAN'S director, po NAME (Type) aucho 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Finksburg, Carroll 5/17/66 Finksburg Cemeterv burial 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. death. PLACE OF DEATH 1. 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY etely filled in by the further bon papers. Pages 1 and within 72 hours after d b. COUNTY e. STATE after MARYLAND b. CITY OR TOWN (If outsida corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give, nearest town) 24 hours KUTA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? NO X letely rbon p within NAME DE First Middle DATE Month Day Year Last 4. DECEASED DF DEATH (Typa or print) 1966 executed SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IFUNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. 8. 7. MARRIED NEVER MARRIED Months Days Hours WIDOWED DIVORCED ttending physician a nit. Then please re or removal, and in 10e. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT be during most of working lifa, even if retired) INDUSTRY COUNTRY? 5 certificate HOUSELL FATHER'S NAME MOTHER'S MAIDEN NAME attending parmit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFDRMANT ddress been signed by the atten the burial-transit permit. In to burial, cremation, or death (Yes, no, or unkown) (If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE DF DEATH [Enter only one cause per line for (a) (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: da attending physician. IMMEDIATE CAUSE (a) 60 DUE TO Conditions, if any, which gava risa to immediate DUE TO cause (a), stating the as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY Health use PERFORMED? certificate NO X 0 PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING IT After this certif I be detached for State Dept. of h DESCRIBE HOW INJURY OCCURRED, (Enter natura of injury in Part I or Part II of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) CAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (County) (State) factory, street, office bldg., etc.) Hour a.m. After d be d While Not While 19 at work at work p.m. should ith the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lied with the saw the deceased alive on and that death occurred at A.M. from the causes and on the date stated above. 229. SIGNATURE 22b. DATE SIGNED director, page should be filed STAFF ATTENDING PHYS. DIRECTOR PHYS. ADDRESS FUNERAL PHYSICIAN'S 22d. Houe Road, Syke sville, Md. NAME (Type) should t BURIAL, CREMATION. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 2 REMOVAL (Specify) REGISTRARIS SIGNATURE FUNERAL DIRECTOR ADDRESS 25a. REC'D BY RECISTRAR VR A15 (4) 20M 1/65



2	1 (M	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1	: =N:	06787 CERTIFICATE OF DEATH
	funeral and 2 and 2 r death.	1. PLACE OF DEATH a. COUNTY a. COUNTY D.
	hours after death d in by the funeral rs. Pages 1 and 2 2 hours after death	Correll Co- MARYLAND MARYLAND CARROLL
	s af by tl age irs af	b. CITY OR TOWN (If outside corporate limits, write PURAL and give nearest town) write PURAL and give nearest town)
	hour S. F. hou	d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
	r filled paper hin 72	Pleasant Valley Pleasant Valley YES NO
	rted within 24 hours after completely filled in by the 1 ve carbon papers. Pages 1 event, within 72 hours after	3. NAME OF First Middle Last 4. DATE Month Day Year
	i wi nple carb ent, i	(Type or print) LUCY REBECCA POWELL DEATH May 24 1966
	executed within and completely remove carbon In any event, with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years US NIDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.
	execu an and in any	XCM21 WIDOWED DIVORCED A/OC/3, 1888 77 yrs.
	icial ease and i	191. USUAL OCCUPATION (Give kind of work done of the first of the firs
	phys n ply val,	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	ding The The	Charles m. Kemple mary Brown
	CIAN: The law requires that the death certificate be obsital or attending physician. Certificate has been signed by the attending physician hed for use as the burial-transit permit. Then please to Health prior to burial, cremation, or removal, and in	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
	the ation	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
	t the an. l by ansil	PART I. DEATH WAS CAUSED BY: Corelisal Hemorrhage ONSET AND DEATH
	ysicia ysicia gned ial-tr ial, c	331X DUE TO COLOR
	uires g phy en si bur	gave rise to immediate (b) Charles Schemes & There Tender
	nding bec	cause (a), stating the DUE TO underlying cause last. (c)
	OR ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. INECTOR: After this certificate has been signed by 3 should be detached for use as the burial-transed with the State Dept. of Health prior to burial, ore	
	The Healt	YES NO
	PHYSICIAN: the hospital this certific detached for	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)
	HYSII le ho his c stach Dept	
	JING PHYSICIAN. Aby the hospital Affer this certif be detached for State Dept. of F.	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. p.m. 19 at work a
	ATTENDING retained by CTOR: After should be vith the Stat	21. I certify that (I) (this hospital) attended the deceased from $4-1$, 1963 to $5-24$, 1966, that (I) (we) last
	ATTE retai cTO sho sho ith t	saw the deceased alive on
	DIRE DIRE ge 3	Weller In allowed PHYS. MED. STAFF 5-ZJ-66
	May May RAL	22c. PHYSICIAN'S NAME (Type) AT GIFN A SPEN HED 22d. ADDRESS
	TO HOSPITAL OR ATTENDING P Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State	1 10-02CM STEPLIER
	Pa Gir She	23a. BURIAL, CREMATION, 23b. DATE THEREOF, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	J	24. EDNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
	VR A15 (4) 15M 4-64	J. S. Myss, A., Westrenster, Max part AN 27 1968 golianles Judge



e. IS RESIDENCE ON A FARM?

Year

19

Hours

INTERVAL BETWEEN ONSET AND DEATH

WAS AUTOPSY PERFORMED?

NO X

(State)

(State)

YEARS

YEARS

19.

DATE SIGNED

(County)

22b.

YES T

Day

Days

12. CITIZEN OF WHAT

5. A

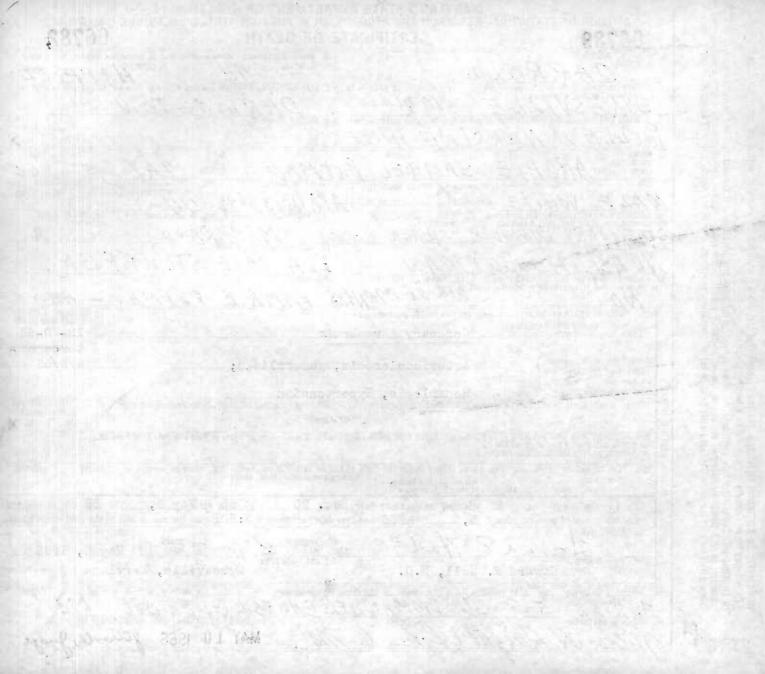
COUNTRY?

NO

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death. PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY Pages 1 after b. COUNTY MARYLAND b. CITY OR TOWN (if dutside corporate limits c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours write RURAL and give nearest town) hours .⊑ bon papers. within 72 h filled NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address e. IS RESIDENCE ON A FARM? d. STREET ADDRÉSS YES NO NO within completely in NAME DE 3. First Middle DATE Month Day Last 4. Year DECEASED event. 1966 (Type or print) DEATH executed SEX гетоме OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) in any Months I and WIDOWED DIVORCED 1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (County & State, or foreign country) physician INDUSTRY COUNTRY? ONA FATHER'S NAME MOTHER'S MAIDEN removal attending permit. Then transit permit. ER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN' Address (Yes, no. or unkown) (If yes give war or dates of service) 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN in signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. 12-20-65 Coronary thrombosis IMMEDIATE CAUSE (a) burial. through DUE TO Conditions, If any, which Arteriosclerosis, generalized: been gave rise to immediate 라라 DUE TO cause (a), stating the underlying cause last. Hemaplegia. Hypertension this certificate has detached for use as CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use PERFORMED? NO IV 2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) of MEDICAL 2Dc. TIME OF INJURY Month, Day, Year | 2Dd. INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) factory, street, office bldg., etc.) Should be do Hour a.m. Not While retained by at work p.m. at work 19 65 to May 5. TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the 21. I certify that (I) (this hospital) attended the deceased from Dec. 20 . 19 66, that (I) (we) last 66, and that death occurred at 8:50M from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED pe ATTENDING PHYS. May 6, 1966 M.D. PHYS. DIRECTOR Page 4 may PHYSICIAN'S 22d. ADDRESS 22 C. NAME (Type) Sykesville, Maryland Howard (State) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) REMOVAL (Specify) FUNERAL-DIRECTOR ADDRESS BY REGISTRAR 25b. 19 VR AIS (4) 20M



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY after the MARYLAND b. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) by bon papers. Pag within 72 hours .Ξ filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ON A FARM? NO Z completely carbon 3. NAME DE Middle DATE Month Day DECEASED OF and in any event, (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 7. MARRIED NEVER MARRIEO етоме Months WIDOWED DIVORCED [12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done during) most of working life, even if retiged) INOUSTRY 11. BIRT HPLACE (County & State, or foreign country) physician that the death certificate or removal, attending Farmit. Then an signed by the attend burial-transit permit. burial, cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: be retained by the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions. If any, which (b) **TO FUNERAL DIRECTOR.** After this certificate has been director, page 3 should be detached for use as the b should be filed with the State Dept. of Health prior to b gave rise to immediate DUE TO (a). stating underlying cause last. CERTIFICATION 19. WAS AUTOPSY for use PERFORMED? YES | NO Z 2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (State) 20d. INJURY OCCURRED 20f. (City or town) TIME OF INJURY Month, Day, Year (County) Hour a.m. While Not While at work et work 21. I certify that (I) (this hospital) attended the deceased from Oct 1964 to 5 27 1944, that (I) (we) last .1944, and that death occurred at 036/M, from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR Page 4 may 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) BURIAL, CREMATION, REMOVAL (Specify) (State) DATE THEREOF NAME OF CEMETERY OR CREMATORY Duni REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AY 3 1 1966 FUNERAL DIRECTOR VR A15 (4) 15M 4-64

Curred to protoments 50 go hatermeter 24 2 Daylet DAVID LEO ROTHENBERGER MAY 27 LL Jun. 6, 1902 by mak white lumber york angline Rund, brotoniste me Maried Volleen Rottenberger Helena Bell 21401 1708 mo. O. Lear Rothenberger Buried 5/51/64 St Man Contline hotel minutes not S. S. Heyora St. Withmenton Ford

	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1	, MARYLAND
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1	write RURAL end giva nearest town)	end give neerest rown)
-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street ddress) d. STREET ADDRESS d. STREET ADDRESS	IS RESIDENCE
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ľ	3. NAME OF First Middle Last 4. DATE Month OF	Dey Yaar
L	(Type or print) JOHN THOMAS POUTZOHN DEATH MAY	5 1966
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDI lest birthday) Months Mark 27, 1886 90 yrs.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Stete, or foreign country) 12.	CITIZEN OF WHAT COUNTRY?
1	Valorer Carroll of mid.	U-S.a.
	13. FATHER'S NAME	
-	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
	(Yes, no, or unkown) (Ifyasgivewerordetesofservica)	
=	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Cerebral otheroscleross	ONSET AND DEATH
	3 3 /4 V DUE TO	7-3
	Conditions, if eny, which (b)	
	gava rise to immediate causa (e), stating the undarlying DUE TO	
	cause last. (c)	
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	OR CONTRIBUTING CAUSE OF DEATH U (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, ferm, 20f. (City or town)	County) (Steta)
	20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (While not While p.m. 19 at work at work 19 at work 1	
	21. I certify that (I) (this hospital) attended the deceased from 11.4. LS	19, that (I) (we) last
	saw the deceased alive on 5/5/6	the date stated above.
	228. SIGNATURE ATTENDING MED. STAFF	22b. DATE
	22c. PHYSICIAN'S M.D. PHYS. DIRECTOR PHYS. DIRECTO	515 46
	NAME (TYPE) DE J. a. Caricofe Union Budge	ml
1	236. BURIAL, CREMATION, 236. DATE THEREOF 236. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City/Town or co	unty) (Stata)
0-	Burnal 3/7/66 Kheadm Brench Combley Kins, M.	Strandy M
1	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'DAY REGISTRAR 25b. REGISTRAR 25b	conley Judge
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- 20204 Marie Marie MAY I U 1966 I WAS TO BE TO SHOW THE REPORT OF THE PARTY OF THE PARTY

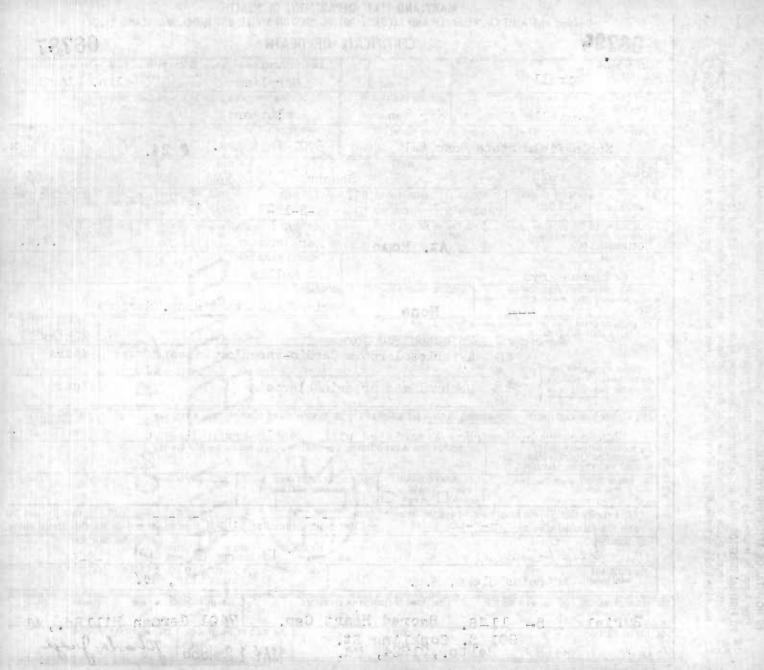
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR ST MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. CDUNTY a. STATE Carro MARYLAND WASHINGTON MARYLAND funeral may be b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town) Rural -- Mt. Ai day HAGERSTOWN the d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 d. STREET AGORESS a. IS RESIDENCE DN A FARM? ay 3 to Page State hours Sandra Lee Motel 51 BROADWAY YES _ NDX dela 3. NAME OF Month First Middle Last 4. DATE Day Year DECEASED (Typa or print) JOYCE JACK RUSE DEATH 1966 Mav 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER I YEAR | IF UNDER 24 HRS 8. 9. 2 with 7. MARRIED NEVER MARRIED Y last birthday) Months Days Hours MALE WIDOWED DIVORCED 27,1912 l and event 10a. USUAL OCCUPATION (GIVa kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working lifa, even if retired) COUNTRY? TAX DIVISION STATE OF MARYLAND MASSACHUSETTS U.S.A any pages in any 13. FATHER'S NAME MOTHER'S MAIDEN NAME 24 h. (tem) ALBERT MARY POWLES File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT FREDERICK, MARYLAND (Yes, no, or unkown) (If yes nive war or dates of service) permit. EXAMINER: This certificate should be executed within certificate, writing the word "pending" in pencil is hould be forwarded to the Chief Medical Examiner's 501 W 2ND. STREET NO 214-09-3463 MRS. DORIS GRIFFIN CAUSE OF DEATH [Enter only one cause per/line for (a). INTERVAL BETWEEN DNSET AND DEATH DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) burial-transit 0 cremation, DUE TO Conditions, if any, which gave rise to immediate DUE TO (a), stating the C underlying causa last. used as to burial, (c) WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION the certificate, writing the should be forwarded to the YES 2Ds. EXTERNAL CAUSE WAS PRIMARY STOT CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW THURY OCCURRED. Enter nature of Injury in Park should ent, pri 3 shou MEDICAL TIME OF INJURY Month, Day, Year 20a. PLACE OF INJURY (Home Jarm, (City or town) 20c. 20d. INJURY OCCURRED 20£ (County Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy inspection and in my opinion DIRECTOR: Natural causes Suicide Undetermined manner death resulted from: Homicide CHIEF MEDICAL EXAMINER for your Page ASSISTANT MEDICAL EXAMINER SIGNATUR 07 FUNERAL OEPUTY, MEDICAL EXAMINER Health **EXAMINER'S** SPE director. retained NAME (Type) NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION. 23b. OATE THEREOF 23c. REMOVAL (Specify) 0 HAGERSTOWN ROSE HILL CEMETER FUNERAL DIRECTOR ADDRESS 25a. REC'O BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR ALSME (5) HAGERSTOWN MARYLAND 1/65

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4	e i	2 5		06793 CERTIFICATE OF DEATH 06786
	hours after death	ter death.	1.	PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE b. COUNTY MARYLAND MARYLAND
	ours after	. 0	1	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
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	xecuted	any eve	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH amulu WIDOWED DIVORCED 3/5/88/ 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR. Months Days Hours Min.
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	ertificat	ermit. Then plea		John Edward Timbeler Sarah Crout.
	eath ce	it permit.	15 (Ye	MAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Proposition (If yes give war or dates of service) 212-10-80620 alice Herstervice) RI #1
	t the dan.	ansit p rematic		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNITERVAL BETWEEN ONSET AND DEATH
	PHYSICIAN: The law requires that the death certificate the hospital or attending physician.	ourial-tr		Conditions, If any, which DUE TO Pulmmary eduna 8 hrs
	w requi	is the trior to		gave rise to Immediate cause (a), stating the underlying cause last. DUE TO Car anoma of tangue = Matastus Zyears
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	COLUMN:	ched fo	1	20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
	of PHYS	tate De	MEDICAL	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20m. 20m
	OR ATTENDING I	should the S		21. I certify that (I) (this hospital) attended the deceased from \$\frac{1}{2}\$, 1966, that (I) (we) lass saw the deceased alive on \$\frac{1}{2}\$ for the causes and on the date stated above
•	y be re	age 3 siled with		22a. SIGNATURE M.D. ATTENDING MED. STAFF DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR PHYS.
	HOSPITAL age 4 may	director, page 3 should be detached for use as the burial-transit permishould be filed with the State Dept. of Health prior to burial, cremation.		22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS CLEMANNIM M
	TO HOSP Page 4	sho		Removal (Specify) 5/25/66 Reisterstown Methodist Reisterstown. Md.
	VR A1:			J. F. Eline & Sons Reisterstown, Md. ADDRESS 25a. REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 2 3 1966 Clicyles Judge.
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MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06795 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death death and completely filled in by the funeral remove carban papers. Pages I and any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE Maryland b. COUNTY Montgomery Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 mo-2 da Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 8510 16th Street YES NO 3. NAME OF Middle 4. DATE Lost Month DECEASED Ethal Nickerson Shaw 19 66 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthdoy) Female White 12-6-83 WIDOWED A DIVORCED 1Qq. USUAL OCCUPATION (Give kind of work done OR DEPLOYED 11. BIRTHPLACE (County & Stote, or foreign country) 10b. KIND OF BUSINESS 12. CITIZEN OF WHAT uring most of working like even if retired)

Boosewase Ket. Stenographer COUNTRY? burial, crematian, or remaval, and attending physician permit. Then please Indiana U.S.A. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME William H. Nickerson Augusta Gilkison 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address signed by the attendir burial-transit permit. (Yes, nor unknown) (If yes give wor or dotes of service) Springfield Hospital Records; Sykesville, Md 578-05-5316 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: DISET AND DEATH Congestive heart failure IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Arteriosclerosis cardiovascular disease vears Conditions, if ony, which gove rise to immediate couse (o), DUE TO far use as the t f Health priar tab stoting the underlying cause TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with arteriosclerosis with neurotic yes 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH director, page 3 shauld be detached should be filed with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work _, and that death accurred at NOA M from co 21. I certify that (I) (this haspital) attended the deceased from 5-29 and that death 19 66, that (A (we) last M, fram causes and on the date stated above. saw the deceased alive an, 22b. DATE SIGNED 5-1-66 220. SIGNATURE MED. DIRECTOR **ATTENDING** OPONS M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Luis J. Arribas Sykesville, Maryland 2178h 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Burnal (Specify) Fort Lincoln Cemetery 4 May 1966 Prince George Co. Md. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 8434 DORESS raia Avenue Silver Spring, Ma. 1966 tarner E. Pumphrey.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06796 CERTIFICATE OF DEATH executed within 24 haurs after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY a. STATE b COUNTY papers. Pages I hin 72 haurs after Carroll MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) 11 mos. 9 dvs. Cumberl and filled in | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? and in any event, within 72 15h Frederick Street Springfield State Hostital NO -3. NAME OF and completely f remave carban Middle 4. DATE Day Year DECEASED SMITH 19 66 ELTZABETH NMN) DEATH Mav (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SFX 8. DATE OF 81RTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Manths Days Hours White WIDOWED DIVORCED 10-21-93 Female 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, ar fareign country) during most of working life, even if retired)

Housewife lease INDUSTRY requires that the death certificate Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remaval, Robert Walker Elizabeth Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, ng, or unknown) (If yes give war or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT No Records, Springfield State Hospital None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH burial-tronsit Bilateral bronchopneumonia signed by 1 IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physicion. DUE TO burial, Conditions, if ony, which gave rise ta immediate cause (a), DUF TO been as the stoting the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS) certificate has PERFORMED? Chronic brain syndrome associated with senile brain disease, without qualifying phrase. Inactive pulmonary tuberculosis.

| ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) far use af Health YES T 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City ar town) (Caunty) (State) Nat While factory, street, affice bldg., etc.) ot work ot work FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram. 5-25-66, 19__, that (I) (we) last 0-10-05 , and that death accurred at 8:15 NP FROM causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SLGNATURE ATTENDING STAFF PHYS. 5-26-66 X directar, page 3 shauld be filed v M.D. DIRECTOR PHYS Springfield State Hospital 22c. PHYSICHAN'S 22d. ADDRESS NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland 21781 230. BURIAL, CREMATION, REMOVAL (Specify) 23 NAME OF CEMETERY OR CREMATORY 23d: LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) OMA ITEM 0 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND				
	08797 CERTIFICATE OF DEATH				
	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence below edmiss 5. COUNTY 6. COUNTY 7. STATE 6. COUNTY				
	Carroll MARYLAND md Corroll				
ı	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)				
l	marchester, and 3 month 442 E Baltimore St, Tanaytown M				
١	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress) d. STREET ADDRESS d. STREET ADDRESS o. 15 RESIDEN ON A FAR				
ı	3. NAME OF FOR Middle Lost 4. DATE Month Dey Year				
l	(Type or print) John William Smith. DEATH 5 12 1966				
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 H				
	Mace widowed of Divorced the 20,1885 8/ yrs.				
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTY 12. CITIZEN OF WHAT COUNTY 13. BIRTHPLACE (County & State, or foreign country) 14. CITIZEN OF WHAT COUNTY 15. CITIZEN OF WHAT COUNTY 16. CITIZEN OF WHAT COUNTY 17. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTY 13. BIRTHPLACE (County & State, or foreign country) 14. BIRTHPLACE (County & State, or foreign country) 15. CITIZEN OF WHAT COUNTY 16. CITIZEN OF WHAT COUNTY 17. BIRTHPLACE (County & State, or foreign country) 16. CITIZEN OF WHAT COUNTY 17. BIRTHPLACE (County & State, or foreign country) 18. CITIZEN OF WHAT COUNTY 18. BIRTHPLACE (Country & State, or foreign country) 18. CITIZEN OF WHAT COUNTY 18. BIRTHPLACE (Country & State, or foreign country) 18. BIRTHPLACE (Country & State, or foreign country & State, or foreign country & State, or foreign country & State, or fo				
ŀ	13. FATHER'S MAKE LISTATE CASCINT. Washington NAME				
١	Il ennis Smith Sugar Miller				
1	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address				
	(Yes, no, or unkown) (Ifyesgive we rordetes of service) 212-32-13194. Elizabeth S. matthew Hampsters				
ľ	1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).) INTERVAL BÉTWEEN ONSET AND DEATH				
١	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Lymphona retropertoned 10 Mo				
ı	2021 DUE TO				
l	Conditions, if eny, which (b)				
١	(e), steling the underlying DUE TO				
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ı	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) PERFORMET PERFOR				
ı	20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH				
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ı	20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State lactory, straet, office bldg., etc.)				
l	p.m. 19 at work at work				
l	21. I certify that (I) (this hospital) attended the deceased from 1966, that (1) (we)				
	saw the deceased alive on				
	22e. SIGNATURE MED. STAFF PHYS. DIRECTOR DIRECTOR DIPHYS. D 5/12/6				
ı	22c. PHYSICIAN'S NAME (Type) W. H. FOARD MP MANCHESTER, Md.				
	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, jown or county) (State)				
	Burnal 3/13/66 Arthers Couldry thing Mosphinsle				
w	24-FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REGISTRAR'S SIGNATURE				
	To MANY 10 1000 MILL IN INC.				

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 requires that the death certificate be executed within 24 hours ofter death death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH DE STAY IN 16 OUR ESTMINSTER e. IS RESIDENCE ON A FARM? (If not in haspital, give street address) d. STREET ADDRESS within 72 E 10 PENNA YES NO IX 3. NAME OF First Middle 4. DATE Manth carbon Last Day Year DECEASED OF DEATH (Type ar print) 19 6 6 SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 70 birthday) Manths Days Hours White Sept. 10, 1895 DIVORCED ony WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? U.S.A. Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Smith Addie E. Shoemaker 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknown) (If yes give war ar dates of service) 0 Mr. Donald Clingan, Taneytown, Maryland INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) buriol-transit PART I. DEATH WAS CAUSED BY: EREBRAL HEMORRHAGE IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stating the underlying cause prior to 'O FUNERAL DIRECTOR: After this certificate has been the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use Heolth NO YES | for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20e. PLACE OF INJURY (Hame, farm, (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o.m. factory, street, office bldg., etc.) Not While at wark 21. I certify that (I) (this hospital) attended the deceased fram 14 1966, and that death occurred at 2007M, from couses and on the date stated above saw the deceased alive on, 22b. DATE SIGNED 22a. SIGNAJURE DIRECTOR PHYS. 22d. ADDRESS PHYSICIAN'S director, pur NAME (Type) 23b. DATE THEREOF 23c. NAME DF CEMETERY OR CREMATDRY 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION REMOVAL (Specify)
Burial May 26. 1966 Taneytown. Reformed Cemetery Maryland 24-FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR Charles 1966 .O.Fuss & Son. Taneytownm Md.



CERTIFICATE OF DEATH Reg. Dist. No. 06792 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NO 3. NAME OF Middle 4. DATE First Last Month Yeor Day DECEASED OF DEATH (Type or print) 19 9. AGE (In years last birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 7. MARRIED DE NEVER MARRIED Months Days WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 16 SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) **DUE TO** Conditions, if any, which gave rise to immediate DUE TO cottse (a), stating the underlying couse last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (State) (County) factory, street, office bldg., etc.) While Hour o. m Not while at work of work p. m. mar 21. I certify that I attended the deceased fram. 19____that I last saw the deceased _____, and that death accurred at \$\frac{43}{D}M\$, from the causes and an the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREO! 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) poge 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A15 (4) 15M 9/55

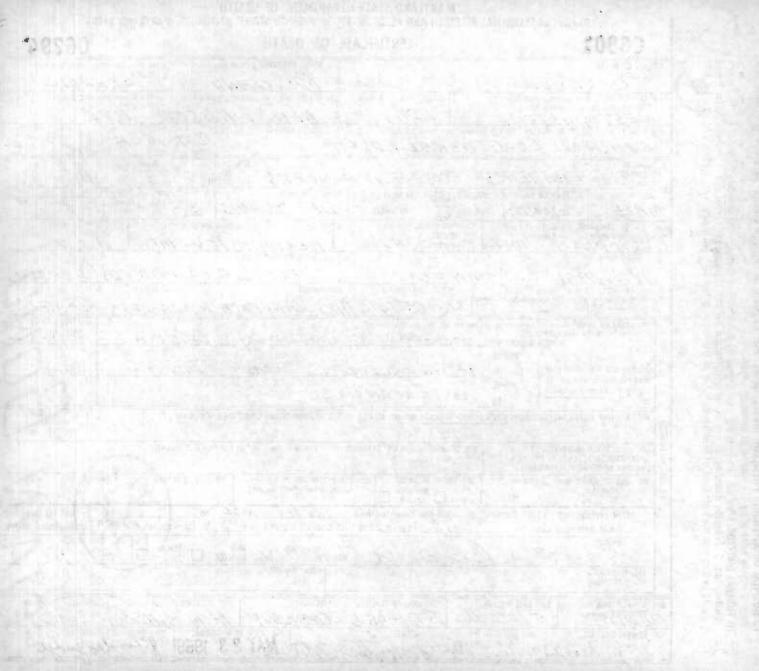
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06800 CERTIFICATE OF DEATH be executed within 24 haurs after death. signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remave carban papers. Pages I and burial, crematian, ar remaval, and in any event, within 72 haurs after deaff 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY o. STATE b. COUNTY Maryland Carroll MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside carparote limits, write RURAL and give nearest tawn)
Sykesville 21211 2 mos./5das. Baltimore e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS 1150 Newport Avenue Springfield State Hospital YES NO PE 3. NAME OF 4. DATE First Middle Manth Year Day DECEASED 19 66 STIMPSON John NMN May DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Months Days Hours 1-29-1882 white WIDOWED X DIVORCED male 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. 8IRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Bricklayer Naturalized INDUSTRY England 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ann ? - dec. William Stimpson, -dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates af service) 100-05-8816 Springfield State Hospital Records no ONSET AND DEATH 18. CAUSE OF DEATH (Enter only ane cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED 8Y: Arteriosclerotic cardio-vascular disease. IMMEDIATE CAUSE (o). Page 4 may be retained by the haspital ar attending physician. DUE TO Generalized arteriosclerosis. years Conditions, if ony, which gave rise ta immediate cause (a), DUF TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the should be filed with the State Dept. af Health priar to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 3 YES 🗀 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Haur a.m. Not While factory, street, affice bldg., etc.) at work at work 21. I certify that (I) (this hospital) attended the deceased from_ 2-25-66 5-1-66 19___, that (I) (we) last . 19 19 and that death accurred at 2:20 M, from causes and an the date stated above. saw the deceased alive an_ 5-1-66 22o. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. 5-1-66 X DIRECTOR M.D. 22d. ADDRESS Springfield State Mospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Octavio Runz. M.D. 23d. LOCATION (City or Town) (Stote) 23a. 8URIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) Baltimore, Maryland L May 1966 Baltimore Cemetery 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR Milanles 1966 Burgee Funeral Home 3631 Falls Road

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06801 CERTIFICATE OF DEATH 06794 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH campletely filled in by the funeral ove carban papers. Pages thand 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY CARROLL a. COUNTY CARROLL MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) hours NEW WINDSOR RTH 1 WESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? BOX 197A CARROLL CO. GENERAL HOSPE YES 🗌 NO 3. NAME OF Middle Last 4. DATE Manth Year DECEASED SUMMERS ROOSEVELT (Type or print) DEATH S. SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED IF UNDER 24 HRS. last birthdoy) Months Days Hours DEC. 26 MALT COLORED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? VESTMINSTER 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, ar unknown) (If yes give war ar dates of service) MRS LAWRENCE K 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY ACUTE IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave HEMRT FRIERIOSCLEROTIC DISIERSE rise to immediate couse (a), HYPERTENSIVE stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES NO for FOR HOSPITAL OR ATTENDING PHYSICIAN Page 4 moy be retained by the hospital 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II af item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) factory, street, office bldg., etc.) Nat While 21. I certify that (1) (this haspital) attended the deceased fram. 1966 19____, that (I) (we) last shauld 1966, and that death occurred at 6 8 M, from causes and an the date stated abave. saw the deceased alive an 5/19 22a. SIGNATURE 22b. DATE SIGNED V director, page 3 should be filed v M.D. DIRECTOR PHYS 22 PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) TJAMER 24. EUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATUR

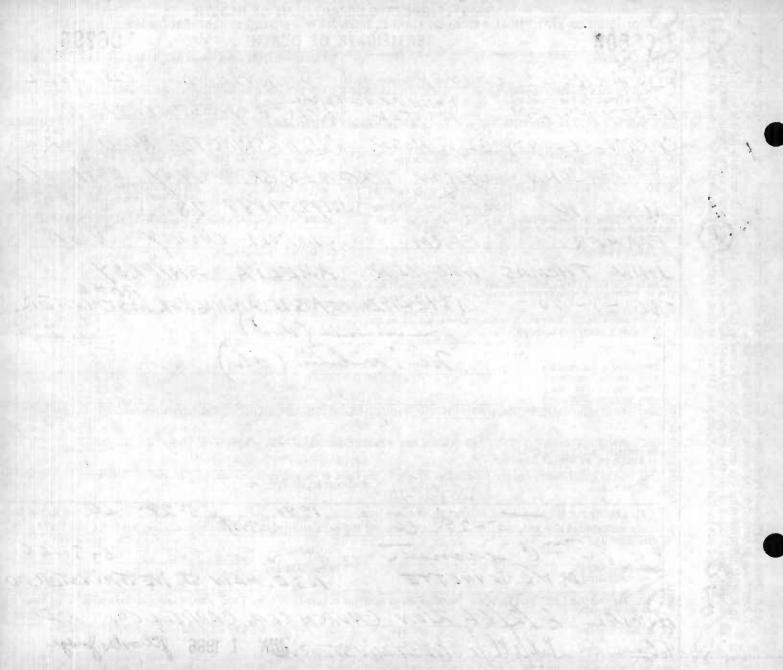


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND 06802 FOR STATE CERTIFICATE OF DEATH MEDICAL EXAMINER'S HEALTH DEPT PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) b. COUNTY Carroll Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) MARYLAND Department after death. the funeral 5 may be CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Frostburg 25vrs.5mos.10dvs Outuber/Land Svkesvilla d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ay is 3 to t Page State Springfield State Hospital Sylvan /Retreat NO S YES 2, and PM3. 3. NAME OF Middle Last DATE Month Year the 72 DECEASED OF DEATH (Type or print) FLORENCE NMN WADE 19 MAY AGE (In yeers | IFUNOER 1 YEAR | IFUNOER 24 HRS 5. SEX after death. If a Give Pages 1, ong with form 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Oavs Hours Female White 7-6-1889 WIDOWED DIVORCED 76 10a, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (Stete or foreign country) COUNTRY? long Housework Maryland pages 1 in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 24 hours Charles H. Wade Lavinia Whittington certificate should be executed within 24 hor iting the word "pending" in pencil in Item ted to the Chief Medical Examiner's Office File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unkown) (If yes give war or dates of service) permit. removal, No 220-511-6273 Records. Springfield State Hospital 18. CAUSE OF BEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. OEATH WAS CAUSEO BY:
IMMEDIATE CAUSE (a) burial-transit cremation, or Acute pulmonary embolism. cause unknown Minutes **OUE TO** Conditions, If any, which (b) gave rise to immediate **OUE TO** (a), stating the C ed as a burial, underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY used to bur PERFORMEO? Mental deficiency, undifferentiated CERTIFICATI YES X NO T Fracture, right 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of Injury In Part I or Pert II of Item 18.)
Apparently was pushed to floor by another patient on "I" pe 0 PRIMARY Tor CONTRIBUTING TO CAUSE OF DEATH. should bent, privil Ward, Warfield Division
20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3 shou Sykesville, (State) MEDICAL (County) 20c. TIME OF INJURY Month, Dey, Year the certificate, While et work at work Springfield State Hospita] 10:30 pm 5-3-66 19 CTOR: Page designated should be and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy IX. Inquiry Inspection FUNERAL DIRECTOR: Health or its design Undetermined manner Sulcide Homicide death resulted from: /Natural eauses Accident CHIEF MEDICAL EXAMINER your 4 execute Page 4 DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURI for DEPUTY MEDICAL EXAMINER DEPUTY **EXAMINER'S** About Side Whitehold, & county Miles please e director. retained W. Glenn Speicher . M. NAME (Type) LOCATION (City, town or county) BURIAL, CREMATION. 23c. NAME OF CEMETERY OR CREMATORY OSTBURG 01 057 24. FUNERAL DIRECTOR Y 2 6 1966 25b. REGISTRAR'S SIGNATURE VR A15ME 3500 4-64

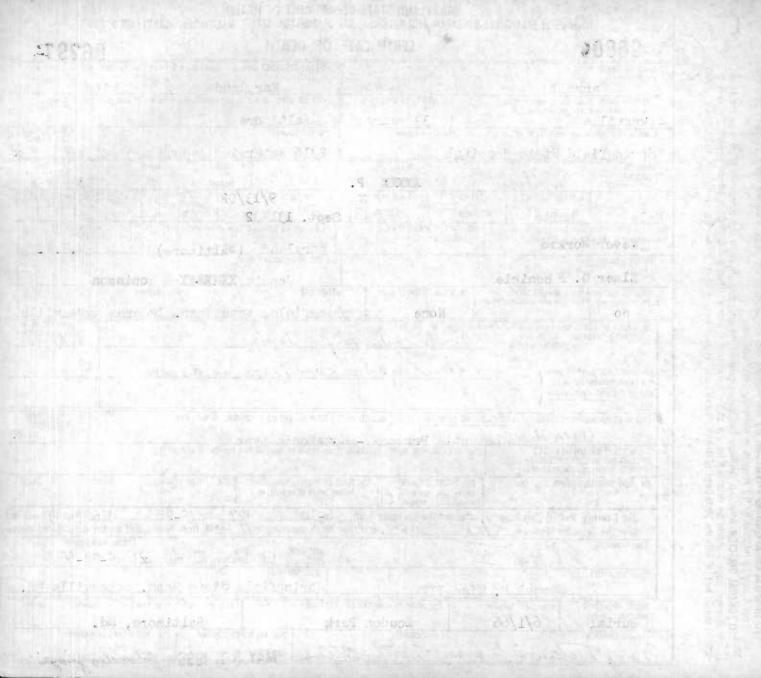
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hours after death. J in by the funeral rs. Pages 1 and 2 i hours after death.	1.	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Res	
e ful	10	a. COUNTY MARYLAND a. STATE D. COUNTY CAR	22011
hours after in by the f s. Pages 1 hours after		b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OF TOWN (If outside corporate limits, write RURAL et	
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filled in papers.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
ithin 24 h etely filled bon papers within 72	5	ARROLL COUNTY GEN. HOSP, WILD WASHINGTON HOAD	YES NO 🗆
completely we carbon event, with	3.	NAME OF First Middle Lest 4. DATE Month OF CTYPE OF PRINT OF CTYPE OF PRINT OF CTYPE	Day Yeer
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PHYSICIAN: The law requires that the death certificate be executed within the hospital or attending physician. this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then plase emove carbon to Dept. of Health prior to burial, cremation, or removal, and it any event, with		(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (Coun	ty) (State)
ING PH by the offer the be det State C	MEDICAL	Hour a.m. While Not While factory, street, office bldg., etc.)	(01010)
retained by terined by terined by terined by terined should be swith the State	25	p.m. 19 at work	that (I) (we) last
y be retained y be retained DIRECTOR: A age 3 should lied with the		saw the deceased alive on 3 - 2 9- 1966, and that death occurred at 3.45 M, from the causes and on the	e date stated above.
R Al			TE SIGNED
AL OR NAY be NA Dage page filed		22c, PHYSICIAN'S ATTENDING MED. STAFF DIRECTOR PHYS. 3-	- 37260
HOSPITAL age 4 may FUNERAL irector, pa			NSTER, MD
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, creating the prior to b	23	DEMOVAL (Specify)	nty) (State)
1 1	1	A FUNERAL DIRECTOR 1250. REGISTRAR 250. REGISTRAR 250. REGISTRAR'S	SIGNATURE
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06804 death. he law requires that the death certificate be executed within 24 hours after death completely filled in by the funeral ave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY hours after Carroll MARYLAND Maryland CITY DR TDWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside carparate limits, write RURAL and give nearest tawn) Sykesville Baltimore vears papers. d. NAME DF HDSPITAL DR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? event, within 72 NO Sc Springfield State Hospital 2816 Waterview Avenue YES 3. NAME OF 4. DATE ave carban Middle Manth Last Day Year DECEASED WAL 1966 1. 10 4 8 DEATH (Type or print) YEAR IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH 9/13/02 AGE (In years last birthday) IF UNDER 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** Months Days Haurs WIDOWED DIVORCED Sept. 131902 Male White attending physician and permit. Then please reg 10a. USUAL OCCUPATION (Give kind af wark done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during mest of working the even if retired) INDUSTRY COUNTRY? Maryland ((Baltimore 13. FATHER'S NAME cremation, ar remaval, Elmer G. Phenicie Jennie Page Co Robinson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, na, ar unknawn) (If yes give war or dates af service) Springfield State Hosp, Records Sykesville no None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) physician. DUE TO burial. Conditions, if any, which gave rise ta immediate cause (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending as the FUNERAL DIRECTOR: After this certificate has been last. PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? detached far use te Dept. af Health CERTIFICATION NO YES Dementia Przecox - Catatonic tyne 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 ar Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 2De. PLACE OF INJURY (Hame, farm, (City or town) 20c. TIME OF INJURY Manth, Day, Year 2Dd. INJURY OCCURRED (County) (Stote) factory, street, affice blda., etc.) Hour a.m. Nat While 19 OR ATTENDING at wark at work pe 1966, that (I) (we) last 21. I certify that (I) (this haspital), attended the deceased fram. 1927 to 5-28 3 shauld be with the S 1966 and that death occurred at 12:35 km, from causes and on the date stated above. saw the deceased alive pn. 22g SIGNATURE 22b. DATE SIGNED **ATTENDING** 5-28-66 M.D. PHYS. DIRECTOR PHYS director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Springfield State Hosp. Sykesville Md Samuel P. Wise 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23a. BURIAL, CREMATION (County) REMOVAL (Specify) Loudon Park
ADDRESS Baltimore. Md 9 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06805 death. requires that the deoth certificate be executed within 24 hours after death filled in by the funeral papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Baltimore City within 72 hours after b. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town)

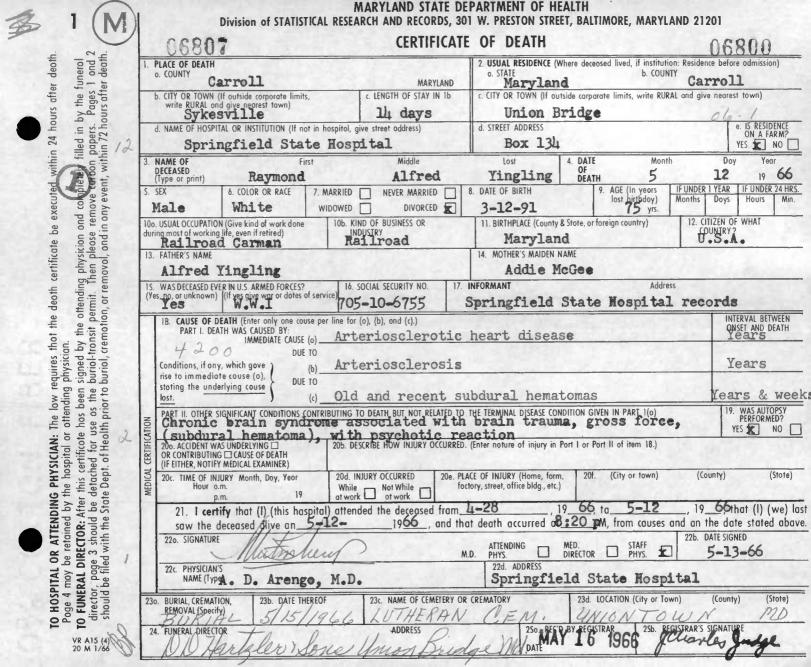
Sykesville c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 1 mo. 5 dys. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 3024 Auchentoroly Terrace YES NO TO NAME OF Middle 4. DATE First Lost Month Day Year DECEASED HERBERT LEE WILLTAMS MAY 19 66 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Manths Days Haurs Male Negro 5-1-20 WIDOWED DIVORCED crematian, or removol, and in or re 1Do. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)
Altchen Helper 12. CITIZEN OF WHAT 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY Virginia U.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Lee Langston Williams Lellia Scott 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, no, or unknown) (If yes give war or dates af service) 230-32-2657 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p DAVS AND DEATH Congestive heart failure IMMEDIATE CAUSE (a) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Poge 4 may be retained by the hospital or attending physician. DUE TO buriol, Severe kyphoscoliosis (causing marked deformity Conditions, if ony, which gove Years rise ta immediate cause (a), of thorax) DUE TO stating the underlying couse as the 19. WAS AUTOPSY PERFORMED? hos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) far use Stote Dept. of Health NO DE this certificate 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City ar tawn) 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While ot wark at wark O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram. 3-31-66 5-6-66 19___, that (I) (we) last 19 , and that death accurred at 1:45 M. Ham causes and an the date stated above saw the deceased alive an 5-6-66 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR STAFF PHYS. 5-6-66 X director, poge 3 should be filed v M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. M. Sykesville, Maryland 23d, LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION, REMOVAL Specify) (County) (State) DATE THEREOF Med. Wed Schoo Oternoso. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR FUNERAL DIRECTOR. VR A15 Milandas Juda

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06806 CERTIFICATE OF DEATH executed within 24 haurs after death. death. ician and completely filled in by the funeral lease remave carban papers. Pages 1 and and in any event, within 72 hours after death I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY arroll o. STATE Maryland b. COUNTY Allegany MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b vrs. 10 mo. 17 Cumberland da. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 214 Columbia Street YES NO X 3. NAME OF First Middle Lost 4. DATE Month Year Doy DECEASED Williams 66 Robert Edward Joseph 19 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SFX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH AGE (In years NEVER MARRIED lost birthdoy) Months Hours Dovs 2-17-0h Male White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT attending physicians. during most of working life, eyen if retired)

Merchant Seaman INDUSTRY COUNTRY? Maryland The law requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, ar remaval, Bernard Williams Mary Sanders 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 525-05-1384 Springfield State Hospital records INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH Coronary artery insufficiency IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Severe coronary arteriosclerosis Years Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse be detached far use as the State Dept. af Health prior ta Bronchopneumonia, bilateral Days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with alcohol intoxication with YES T NO psyc 120t DESCRIBE HOW INVERY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o.m. Not While foctory, street, office bldg., etc.) 19 ot work ot work 19 66 that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from 6-29 19 59. to page 3 shauld e filed with the saw the deceased alive on 5-13-19 66, and that death accurred \$2:05am, from causes and on the date stated above. 22b. DATE SIGNED 220. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. 5-13-66 OR M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital NAME (Type)A. D. Arengo. M.D. director, I 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL MAY 16,1966 CUMBERLAND MD PATRICKS CEMETERY
ADDRESS 1250 9 250 MAYBY REGISTRAP 966 25b. AEGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 BYRON KIGHT CUMBERLAND, MD.

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:	Ine law requires that the death certificate be or attending physician, sate has been signed by the attending physician use as the burial-transit permit. Then please alth prior to burial, cremation, or removal, and it		PART I. DEATH WAS CAUSED BY:	1/	- 1.0	9	ONSET AND DEATH
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	HYSIGIAN: the hospital this certific letached for		(IF EITHER, NOTIFY MEDICAL EXAMINER)			KUR A KELL	miles send the land
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	L DR ATTENDI by be retained DIRECTOR: A age 3 should filed with the		saw the deceased alive on Thurst	4 1966, and that	death occurred at 113AM, f		
	₩ m >	8 5	22a. SIGNATURE				DATE SIGNED
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		2	. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REG	ISTRAR 25b REGISTRAF	R'S SIGNATURE
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